NO TIME FOR MARK | The Gap Between Policy and Practice

SPECIAL INVESTIGATION REPORT MAY 2015

SASKATCHEWAN advocate
a Voice for Children and Youth

Letter of Transmittal

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May 20, 2015

The Honourable Dan D'Autremont
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
Regina SK S4S 0B3

Dear Mr. Speaker:

In accordance with Section 29 of *The Advocate for Children and Youth Act*, it is my duty and privilege to submit to you and the members of the Legislative Assembly of Saskatchewan this special investigation report: *No Time for Mark: The Gap Between Policy and Practice.*

Respectfully submitted,

Bob Pringle

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To harmonize page numbering between the online and printed version of this report, page numbering has been modified to follow the emerging design standard, with the cover page as Page 1

This report is an examination of the services provided by the Ministry of Social Services (MSS) to a young child we have called Mark, and to his family. Mark was in the care of MSS from the age of seven months until his death at age twenty two months. As per the legislation governing this office, the report does not identify Mark by his real name.

Executive Summary

Mark was born on August 6, 2008 and was being cared for by his mother. MSS had previous involvement with Mark's family due to issues of mental health and domestic violence. After Mark was born, the MSS became involved with Mark's mother when these issues persisted. On March 13, 2009, Mark and his older brother were apprehended by MSS due to reported concerns about Mark's mother's ability to care for them. As a result, the children were placed with extended family members.

MSS was involved with Mark's mother through the use of voluntary agreements until the fall of 2010 when it was determined that Mark's mother was not making the necessary changes to be able to resume care of her children. MSS took the matter to court and Mark was made a temporary ward. At that time, MSS considered whether Mark's father and extended family could be a permanent resource for him.

For the majority of his time in care, Mark remained with extended family until they could no longer care for him. On April 1, 2010 Mark was moved to the Saskatoon Crisis Nursery for 12 days until a foster care placement could be found. MSS was in the process of approving another extended family member as a resource for Mark but it was not completed before he passed away.

On April 12, 2010, Mark was placed into a foster home. The foster home had been approved to care for three foster children. When Mark was placed in the home, he was the fifth child and all of the children were under four years of age. The foster home only had one bedroom for foster children and they used a basement bedroom for Mark and another foster child. The foster parents were not provided any additional support to assist them to care for the number of children in their care.

Mark died on June 8, 2010 and the circumstances of his death were the subject of a court case as the foster mother was charged with criminal negligence causing his death. The matter proceeded to court and she was found not guilty. The Coroner ruled that Mark's death was accidental.

The purpose of this investigation is to determine whether MSS provided Mark and his family services to which they were entitled. It is also to identify whether there were any gaps in service provision or compliance with policy or procedures that may have contributed to or failed to prevent the events that lead to Mark's death. Based on the findings of the investigation, the report makes recommendations to improve the delivery of services and ensure that the rights of children are upheld.

Key findings of the report include:

- MSS failed to keep Mark's best interest foremost when they arranged for his placement into an overcrowded foster home without any assessment of the home's capacity to manage five young children placed in their care, contrary to policy. MSS did not act quickly to approve extended family to become a resource for him and the conditions under which he resided were not seen by his caseworker. MSS did not take any steps when alerted to the deficiencies of the home or in Mark's case file. The investigation found that MSS did not act as a prudent parent and violated Mark's rights to a safe and secure environment while in their care. In this regard, the investigation concluded that Mark's death was preventable.
- The investigation found countless occasions when MSS practice did not meet the requirements of policy; and in particular in the absence of required case assessment and child development and assessment plans and child contact standards. The noncompliance with policy affected MSS's ability to ensure that Mark and his family received the services to which they were entitled.
- MSS's practices did not follow policy requirements with respect to the approval and oversight of the foster home. Policy was not followed when MSS conducted an investigation of the foster home. MSS did not properly assess the foster home when they decided to place more than three children in their care and allowed the foster home to be in an overcrowded situation without support services.
- Supervisor and senior management oversight were not effective to ensure that policy was followed. There was an absence of critical thinking when

matters were reviewed and approvals were provided with insufficient information to make decisions. On a number of occasions, supervisory approval was provided despite noncompliance with policy.

- The issues of overcrowded foster homes and workload remain a concern. Overcrowding continues to impact the ability of MSS to ensure appropriate resources are available for children.

The Advocate recognizes in the five years since Mark's death, MSS has made significant changes toward improving the services provided to children and families. However, systemic issues remain, pertaining to the lack of quality case management and supervision, lack of policy compliance generally, adherence to required contact standards when a child is placed into an out-of-home resource, the quality of investigations, and the continued need to place children in foster homes which are over their recommended capacity.

The recommendations from this investigation include several which are relevant from special investigations released in 2014. Relevant recommendations from *Two Tragedies: Holding Systems Accountable* are: that MSS ensure high quality child protection casework by evaluating the use of the SDM tools; provide certification and clinical oversight in their use; and contract with the Children's Research Centre to conduct a workload estimation study that determines standards for caseload size in Saskatchewan, to then be implemented.

Relevant recommendations from *Lost in the System: Jake's Story* are: that MSS conduct a review and analysis of moves children and youth experience in out-of-home care; that MSS implement the software in their database system to track these moves; that the Government of Saskatchewan license foster homes; that MSS conduct mandatory investigations of foster home incidents involving highly vulnerable children; and that MSS require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies.

In Mark's case, the Advocate recommends:

- That MSS conduct a review and amend its policies pertaining to the investigation of foster homes to ensure that investigations are conducted in a thorough and comprehensive manner, and are compliant with the principles of fairness.
- That MSS provide training to staff who are assigned to conduct or supervise foster home investigations related to the principles of fairness and their application to an investigation process.
- That MSS conduct a review of their foster home program, in order to determine those factors that have resulted in a rapid decline in the number of foster homes, and that includes a plan to address this decline.
- That MSS amend its policy to require that an In-Home Support contract and required staff are in place prior to the placement of a child, when it is assessed that a foster home requires In-Home Support services.
- That MSS evaluate the recent changes made to the structure of its placement process and provide a report to the Advocate for Children and Youth in six months that outlines the impact of those changes on the ability of staff to match a child to an out-of-home resource.
- That MSS include the use of the Structured Decision Making® placement matching tool, or similar tool to guide placement matching decisions.
- That MSS develop internal procedures to ensure that issues requiring immediate attention, as identified through a Quality Assurance Unit review, are addressed in a timely effective manner and the actions are reported back centrally.
- That MSS create and implement procedures in their current policies related to a critical incident or child death around how natural families are notified and provided with support services, and how the First Nations bands or agencies are notified.
- That MSS offer a formal letter of apology to Mark's parents for not acting in Mark's best interests during the time of his last foster home placement.

Mark's story demonstrates how tragic events can occur when there are repeated failures to follow policy, and when oversight mechanisms fail to address matters of persistent noncompliance. I have called this report *No Time for Mark: The Gap Between Policy and Practice* because the repeated evidence of noncompliance cited in this investigation illustrate that MSS staff did not take the time to follow policy and provide Mark and his family with the services to which they were entitled. While it is too late for Mark, it is our hope that with this report, we can close the gap between policy and practice for children who come after him. ◆

1. Introduction

1.1 Circumstances of the Incident

On June 10, 2010, at approximately 5:05 p.m., the RCMP received a 911 call reporting that a child had been injured at a foster home located on an acreage near Saskatoon, Saskatchewan. Twenty-two month old Mark was found by his foster father face down in the bathtub with the taps running. Information obtained from the court decision[1] reflects that the foster mother left Mark in the bathtub in approximately two inches of water with the taps turned off while she went to discuss an issue regarding another foster child with the foster father. The foster parents' daughter came to report that she heard running water in the bathroom. The foster father immediately went to the bathroom, removed Mark from the tub of hot water and began CPR. The foster mother phoned 911. First responders arrived and continued CPR. The ambulance arrived a short time later and paramedics intubated Mark, and administered medications and lifesaving treatments while transporting him to the hospital. Mark was pronounced dead at 5:51 p.m., shortly after his arrival at the hospital.

The Advocate conducts investigations to identify any contributing factors leading to deaths or critical injuries of children and youth and make recommendations for improvements

The report of the Coroner found the medical cause of death to be drowning and the manner of death was accidental. The post-mortem examination of Mark found evidence of some lung congestion, scalding burns over a large part of Mark's body and some abrasions and soft tissue bruising of his scalp. There was no evidence of any significant trauma or other medical factors that played a role in his death.

In the aftermath of Mark's death, the foster mother was charged with criminal negligence and the matter went to trial. On February 1, 2013, the court found the foster mother not guilty. The Crown Counsel launched an appeal of the decision, however, withdrew the appeal in November of 2013. In early January 2014 the foster mother passed away.

1.2 Mandate and Purpose

The Advocate for Children and Youth is an officer of the Legislative Assembly of Saskatchewan. The mandate for the Advocate's work is found in *The Advocate for Children and Youth Act*. The *Act* outlines the manner in which the Advocate can perform the mandated duties and includes advocacy, investigation, public education, and research.

The Advocate can serve notice to investigate any matter that comes to his attention from any source concerning a child or youth who receive services from any ministry, agency of the government, or publicly-funded health entity. Investigations are conducted to identify any contributing factors leading to deaths or critical injuries of children and youth and to make recommendations for policy or service delivery improvements for consideration by the provincial government. Investigations that are publicly released by the Advocate are done so for the purpose of making the information known about issues that are historically or currently affecting children, and also to hold government accountable regarding services to children and youth.

The Advocate's work is grounded in the United Nations *Convention on the Rights of the Child*, an international human rights treaty that was ratified by Canada in 1991.[2] The Advocate has distilled the rights and obligations into the *Saskatchewan Children and Youth First Principles*.[3] The Government of Saskatchewan adopted these principles in 2009 as a mechanism to strengthen its child welfare system and to promote the rights and entitlements of children and youth by all government ministries.[4] The principles reflect the core beliefs and values held by the Advocate for Children and Youth and provide a guide for examining how government delivers its services. The principles outline the rights of children and youth and state that children and youth are entitled to have their

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Saskatchewan Children and Youth First Principles

We believe that all children and youth in Saskatchewan are entitled to:

- Those rights defined by the United Nations *Convention on the Rights of the Child*.
- Participate and be heard before any decision affecting them is made.
- Have their best interests given paramount consideration in any action or decision involving them.
- An equal standard of care, protection and services.
- The highest standard of health and education possible in order to reach their fullest potential.
- Safety and protection from all forms of physical, emotional and sexual harm, while in the care of parents, governments, legal guardians or any person.
- Be treated as the primary client, and at the centre, of all child-serving systems.
- Have consideration given to the importance of their unique life history and spiritual traditions and practices, in accordance with their stated views and preferences.

Touchstones of Hope for Indigenous Children, Youth and Families

The *Touchstone of Hope* principles are meant to be interpreted within distinct cultures and contexts of Aboriginal communities according to a four-stage reconciliation process:

Relating: Working respectfully together to design, implement, and monitor the new child welfare system.

Restoring: Doing what we can to redress the harm and making changes to ensure it does not happen again.

Truth Telling: Telling the story of child welfare as it has affected Indigenous children, youth and families; and

Acknowledging: Learning from the past, seeing one another with new understanding, and recognizing the need to move forward to a new path.

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1. Reference from the Court of Queen's Bench file.

2. United Nations General Assembly. Convention on the Rights of the Child.1989. Available from://www.unicef.org/crc

3. Children and Youth First Principles, Saskatchewan Advocate for Children and Youth. Available from: http://saskadvocate.ca/children-youth-first/children-youth-first-principles

4. Government of Saskatchewan. Putting children first: province takes action on child welfare [Press release]. February 25, 2009. Available from: http://www.saskatchewan.ca/government/news-and-media/2009/february/25/putting-children-first-province-takes-action-on-child-welfare

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"best interests" given paramount consideration in any action or decision involving them. Children and youth are to be treated as the primary client, and at the centre, of all child-serving systems.

Through telling Mark's story, we acknowledge and learn from the past, make recommendations to redress the harm, and work together to monitor and implement changes needed to improve child-serving systems

The Saskatchewan Advocate for Children and Youth has also adopted the *Touchstones of Hope*[5] as part of its Guiding Principles when promoting child welfare system change and working with Aboriginal children, youth and families. These principles emphasize the need to work together, redress harm and make changes, tell the story of child welfare, and acknowledge and learn from the past to move forward. They recognize the need for a holistic approach to child welfare that reflects the reality of the whole child, preserves the continuity of relationships, and recognizes that children are shaped by their culture, environment, social relationships, and specific abilities and traits.

This investigation provides an opportunity to tell Mark's story, acknowledge and learn from the past, make recommendations to redress the harm, and work together to implement and monitor changes that are needed to improve child-serving systems. While Mark died five years ago, the Advocate believes that Mark's story deserves acknowledgement and understanding of what occurred during his brief life. Despite changes in policies and practices in the Ministry of Social Services (MSS), the Advocate observes that Mark's history has illustrated that there are ongoing challenges in the child welfare system, and a need for improvements in the services delivered to children and youth.

Mark's history has illustrated that there are ongoing challenges in the child welfare system

1.3 Scope and Methodology

The investigation conducted into circumstances leading to Mark's death reviewed the periods of time which MSS services were delivered to Mark and his family prior to his birth and during his entire life. The investigation also examined how Mark's family was treated when notified of his death. During this investigation, all available documentation related to Mark's case was reviewed, which included documentation from the Ministry of Social Services, the Saskatoon Health Region, Saskatoon Crisis Nursery, the Saskatchewan Foster Families Association, the Office of the Chief Coroner, and select court transcripts. Interviews were conducted with staff from the Ministry of Social Services (MSS), the Saskatoon Crisis Nursery, the Saskatchewan Foster Families Association, and the Saskatoon Health Region. Some family members and care providers also provided information.

As part of this scope, the investigation examined the draft Joint Child Death Review that was conducted by MSS and Sturgeon Lake Child and Family Services Inc. (CFSI) The final report, which would include the MSS action plan to address the recommendations of the review, was not available at the time of our investigation. MSS and Sturgeon Lake CFSI were given the opportunity to review and provide comments on the facts outlined in this investigation to ensure the report fairly and accurately captured the history of Mark's case. The Advocate thanks MSS and Sturgeon Lake CFSI for their cooperation.

The investigation considered whether MSS fulfilled its obligations to Mark and his family under *The Child and Family Services Act* and related MSS policy and procedures. It also considered whether services to Mark respected and adhered to the principles of children's rights and were child-centred.

5. Blackstock, C., Cross, T., George, J., Brown, I, & Formsma, J. Reconciliation in child welfare: Touchstones of hope for Indigenous children, youth, and families. Ottawa, ON, Canada: First Nations Child & Family Caring Society of Canada / Portland, OR: National Indian Child Welfare Association, 2006. Available from: http://www.fncaringsociety.com/sites/default/files/Touchstones_of_Hope.pdf.

2.1 The History of Mark's Family with the Ministry of Social Services

Mark's mother's involvement with MSS began when she was a child. She was in and out of foster care for most of her childhood. MSS concluded her case when she turned 18 years of age. In 2006, MSS resumed its involvement after being notified of concerns about her ability to care for Mark's older brother, who was three weeks old at the time.

2.0 Chronology of Services to Mark and his Family

The reports to MSS at that time were related to concerns about her emotional stability, her mental health, and reports of a volatile relationship with her child's father. Mobile Crisis and the police were often involved and a restraining order was evoked due to domestic violence. MSS conducted two investigations and found no evidence that Mark's older brother was harmed or injured. However, the investigations found that there was ongoing domestic disharmony that would likely increase the risk of harm to their child as he grew older. The investigations assessed that the risk was low, due to the support of extended family and the separation of the couple.

In the following six months, MSS received four other reports about the family related to the volatile relationship and concerns about the mother's mental state due to her threats of suicide. Each time, Mobile Crisis responded and determined that Mark's brother was safe and that his mother was fine and capable of managing his care.

In November 2007, MSS received further reports that Mark's mother was not coping well and conducted another investigation. MSS found that Mark's mother lost significant family support, had not taken Mark's brother to a doctor as requested by MSS staff, and there were ongoing parental disputes. MSS determined that Mark's brother was in need of protection, however did not apprehend him as Mark's mother agreed to sign a Parental Services Agreement (see text box) which is an agreement between MSS and the parent(s)for services to assist the family. Mark's mother accepted services from MSS and agreed to work with a parent aide, ensure that her son received medical attention with MSS's support, and explore counselling. Shortly after the agreement was signed, Mark's older brother was apprehended as Mark's mother requested he be placed elsewhere as she reported having difficulty coping and described conflict with Mark's father.

MSS policy[6] directs staff to explore "extended family or others significant" (also referred to hereafter and includes an alternative care provider) to the child as the first arrangement for the care of the child (refer to text box). Prior to placement of a child into any extended family placement, MSS[7] must complete certain checks to ensure the safety of the child and suitability of the placement for the child. For all placements with extended family, MSS must conduct a home visit to complete an Extended Family Home Safety Check to ensure that the home meets safety and health standards. MSS now searches their Automated Client Index and Linkin systems to review if there is any child protection history that could place a child at risk. Criminal records checks from all adults residing in the home are required. To expedite the process, MSS policy[8] permits the use of self-declaration forms in which the adults declare whether they have a criminal record and if so, the nature of any convictions until the formal record is received. If the home of the extended family is to be approved as an alternative care provider, MSS is required by policy to complete an extended family assessment (also known as a home study), including personal references, within 30 days of the child's placement.[9]

MSS placed Mark's brother with an extended family member as a place of safety (see text box) in order for him to be moved quickly. MSS then completed the requirements for the home to be approved as an alternative care provider. Mark's

6. MSS, Children's Services Manual – 4.3 & Children's Services Manual 2.3

7. MSS, Children's Services Manual – Chapter 4

8. MSS, Children's Services Manual – 4.3.3

9. MSS, Children's Services Manual – 4.3.4

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mother signed an Agreement for Residential Services under Section 9 of *The Child and Family Services Act*. Section 9 Agreements occur in conjunction with the Parental Services Agreements and allow the parent(s) to voluntarily place their child in the care of the Minister of Social Services when they are not able to meet the child's needs. Mark's brother remained in MSS's care while she completed the terms of the Parental Services Agreement that included registering for counselling and visits with Mark's brother. Mark's father was not part of this agreement or considered a resource given the parent's volatile relationship, and the concern that he had previously returned Mark's brother to the mother's care despite reported concerns about her emotional well-being.

The Assessment and Case Plan for the family was not completed during the time of MSS's involvement with the family

In the following months, Mark's mother reported that she was pregnant and not living with the father. The original Parental Services Agreement signed was changed and no longer required that she attend counselling unless she reconciled with the father. Parent aide services reported that Mark's mother was improving in her ability to care for her son. By the end of March, she was having regular daytime and overnight visits and Mark's older brother was returned to her care on April 1, 2008. The MSS worker conducted two home visits within the following six weeks. The worker determined there were no concerns about Mark's mother's ability to care for Mark's brother. However, there was no risk assessment completed at the time, contrary to policy.[10] The file was closed on MSS's database system on May 28, 2008.

The Assessment and Case Plan for the family (see text box), was not completed during the time of MSS's involvement with the family. Rather, the plan was completed two months after file closure on July 31, 2008 and approved by the supervisor on August 7, 2008, contrary to MSS policy, which requires that the plan be completed within 90 days of the conclusion of an investigation.[11] The plan concluded that over the past four months there were no further intakes related to domestic violence, the mother had worked with the parent aide, interacted appropriately with her son and was involved in the Healthy Mother Healthy Baby program.[12] Extended family was supporting the mother and would provide child care when the mother delivered her second child. The mother had agreed to inform MSS if she was reconciling with the father so counselling could be arranged. The Assessment and Case Plan did not make reference to a parent aide critical incident report that reflected observations of injury to Mark's mother. The report indicated that Mark's mother refused to discuss what had happened. This observed injury occurred on the same day that the Mark's brother was returned to her care and there was no information on file indicating this was followed up by the worker.

2.2 Mark is Born

Mark was born on August 6, 2008. Medical reports indicate that he was a full term baby, however had several medical issues which required that he spend time in the Neonatal Intensive Care Unit. He remained in hospital until August 15 when these issues were resolved, and he was discharged home as a healthy infant. File reports indicate that Mark's mother had several discussions with the hospital social worker and voiced being more prepared and capable of parenting this time. The hospital social worker provided her with information about postpartum depression because of her history with Mark's older brother. Information regarding the Saskatoon Tribal Council parenting support programs[13] were also discussed, as Mark's mother was not eligible for the government of Saskatchewan's *KidsFirst* program, as she did not reside in a neighbourhood where the program was offered at that time.[14] Referrals were also made to public health and the Healthy Mother Healthy Baby program for follow-up at the home as Mark's mother had participated in the program

10. MSS, Children's Services Manual – 2.7

11. MSS, Family-Centred Services Manual – 4.2

12. The Healthy Mother Healthy Baby program is delivered by the Saskatoon Health Region and offers information, education, advocacy and support in clients' homes. It is designed for pregnant teens and women who are living in the community, and have various risk factors such as food insecurity, low income, isolation, substance abuse, and inadequate housing.

13. Saskatoon Tribal Counsel provides a variety of family support programs to STC member communities and off reserve First Nations residents of Saskatoon and area. The aim of their programs is to strengthen the family unit. Supports are offered through in home visiting, advocacy, day programs, et al.

14. *KidsFirst* is a home-based early childhood development program offered to families who would benefit from additional support in areas that have an impact on child health and development and family well-being. A team of professionals provide the service by weekly home visits to families with children from birth to age five.

Types of Extended Family Placements

Placement with Extended Family

Extended family are relatives, members of the child's band, godparents, stepparents or other adults who are important in the child's life.

Categories of Extended Family

Private Arrangement

The parent(s) sign an agreement with the extended family for their child's care.

Place of Safety

MSS approves extended family as a place of safety for a maximum of 10 days.

Alternative Care Provider

MSS approves an alternative care provider as an alternative to foster care

Persons of Sufficient Interest

The court approves an application from an extended family to be designated as a Person of Sufficient Interest. Once the court makes this designation, a child placed in that resource is no longer a child in care of the Ministry of Social Services.

Parental Service Agreements

A Parental Services Agreement is a voluntary agreement signed between a child's parents and MSS reflecting their desire to work together in the best interests of the child. The Agreement outlines the reason for child and family services involvement and identifies the tasks and outcomes to be achieved by the parents and MSS staff. These agreements are typically 120 days in length and can be renewed or amended as necessary. If MSS staff believe a child requires protection, either or both parents will be asked to sign a Parental Services Agreement. If parents are unwilling to sign an agreement, MSS is required to make an application to court for a protection hearing, for a judge to determine whether the child is in need of protection. (MSS, Family-Centred Services Manual, Ch. 5, Sec. 2)

Assessment and Case Plans

An Assessment and Case Plan is the formal documentation of the case planning process to ensure:

- There is a mandate for Ministry of Social Services' involvement.
- The caseworker has structured his or her thinking about the assessment and planning process with the family.
- The steps of the plan are being implemented in a timely way.
- Supervisory reviews are completed.
- Documentation is available for communication with other service agencies, professionals or the court.

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sporadically during her pregnancy. Although the father was not living with Mark's mother, he also met with the hospital social worker when Mark was being discharged. He had no concerns about Mark coming home and indicated that he and extended family would provide support.

The Healthy Mother Healthy Baby program discharged Mark's mother from their program, noting that follow-up services would be provided by Public Health. Public Health records indicate that the family was seen within a week of discharge, and again in November 2008 and February 2009 for Mark's immunizations.

Although MSS had evidence that Mark's mother was still struggling emotionally, this was not identified in the agreement, and counselling services were not part of the agreement

2.3 MSS Resumes Involvement with the Family

In November 2008, MSS received reports of domestic conflict and that Mark's brother had been injured. This report triggered an investigation which was completed within 30 days as per policy[15] and concluded that the children were in need of protection due to the domestic disharmony. MSS staff examined both children and found no noticeable injuries. Although reluctant and upset with the workers, Mark's mother agreed that she would accept services. She signed the first of a series of four Parental Services Agreements after MSS resumed its involvement with her. In the first agreement, which ran from November 13, 2008 to January 13, 2009, the reason for involvement was listed as allegations of domestic violence in the home when children were present. In the agreement, Mark's mother agreed to work with a parent aide to obtain a custody order, get help with budgeting, attend the Healthy Mother Healthy Baby program (a program that she was no longer eligible for) and explore the domestic violence program. MSS was to arrange for parent aide services and provide information on the domestic violence program.

Although MSS had evidence that Mark's mother was still struggling emotionally, this was not identified in the agreement as an issue and counselling services were not part of the agreement. The MSS workers advised that the Parental Services Agreement terms were developed with the parent and could later be amended as counselling or a mental health assessment could take months to put into place. It is noted that the conditions of the Parental Services Agreement included her attendance to the Healthy Mother Healthy Baby program. MSS staff reported limited familiarity with the program and how its services were delivered.

During this time, the child protection worker made arrangements for a parent aide contract and learned from Mark's mother that the boys' father was leaving the community and that she would not require domestic violence programming. The worker observed that Mark's mother was isolated and had difficulty getting out. The parent aide was to assist her with building community support.

On January 15, 2009 a second agreement was signed between MSS and Mark's mother for the period of January 15 to April 15, 2009. In this agreement, there was no reference to the domestic violence program. Mark's mother agreed to continue to meet with the parent aide twice a week, work on housing, schooling and parenting (if needed) and continue to attend the Healthy Mother Healthy Baby program, although the program was not available to her. MSS agreed to remain in contact with Mark's mother and get more information about the *KidsFirst* program for her.

Mark's mother struggled with the terms of the Parental Services Agreement. She initially questioned the reason a second agreement was needed. She did not regularly meet with her parent aide or attend recommended parenting programs. In February 2009, the child protection worker met with Mark's mother and the parent aide to review the terms of the contract. Mark's mother voiced being depressed but agreed to start attending parenting classes. Case notes indicated that Mark's father may have been residing in the home but no steps were taken in relation to this information and there were no changes made to the Parental Services Agreement.

MSS policy required that an Assessment and Case Plan be completed 90 days after the conclusion of the investigation record, in this

case by February of 2009, to comprehensively assess the needs and services that this family required. Although this requirement was highlighted in the investigation report and in formal supervision sessions, the Assessment and Case Plan was not completed, contrary to MSS policy[16] and remained outstanding until after Mark's death.

2.4 Mark and his Brother are Taken into Care

In March 2009, a series of events and subsequent reports led to the apprehension of Mark and his brother. Callers reported to MSS that Mark's mother had issues of substance abuse, mental health and may have neglected the children. The child protection worker interviewed the callers, and found that the boys were being cared for by different family members. The child protection worker consulted with her supervisor and, given the reported concerns, a decision was made to apprehend Mark and his brother. The child protection worker subsequently met with Mark's mother on March 16, 2009. She was upset about the apprehension and refused to provide details to the worker about her circumstances. She admitted using substances but denied being suicidal and would not "safety plan" with the worker. When advised that the children would not be returned to her care, she agreed to sign a Section 9 Agreement for the boys to remain in the care of MSS for three months, while she attempted to address the issues which led to their apprehension. Mark's mother also identified an extended family member who she felt could be a resource for Mark. Although MSS was already involved with Mark's family, policy requires that an investigation report be completed when there is new referral information on existing cases. In this case, MSS did not complete an investigation report, contrary to policy.[17] Further, there was no risk assessment tool (which is part of the investigation process) completed to evaluate the severity of risk to Mark and his brother.

2.5 Mark is Placed with an Alternative Care Provider

On March 13, 2009, Mark was placed in the home of the extended family member who was caring for his older brother. This particular family member had been the alternative care provider for Mark's brother the previous year but had not continued to be an approved caregiver. Mark's placement was documented as a "weekend" visit and it is unclear whether the placement was intended to be a place of safety. MSS began the process to approve the extended family as a place of safety by collecting self-declaration criminal record checks, but did not complete an Extended Family Home Safety check, contrary to policy.[18] It also appears that the Mark's father was living in the extended family home and caring for the children while they were on apprehended status. Unfortunately, this family member reported being unable to care for both boys, and they were moved to a foster home on March 17, 2009.

When Mark's mother identified a different family member that could be a resource, the child protection worker took immediate steps required by policy to have this extended family approved as a place of safety.[19] On March 18, 2009 Mark and his brother were moved to this family's home as a place of safety, where they remained for the next three months. During this time, an extended family assessment and formal criminal record checks were completed to conclude the approval process for the extended family to become the official alternative care provider. Although the process was delayed as the formal criminal record checks were late in being received, managerial oversight and approval was obtained for the delay.

MSS records indicate that when the alternative care providers were approved, MSS staff informed them that Mark and his brother were being placed for three months and that an extension would likely be required. At the time, there was no requirement for a formal agreement to be signed between MSS and the alternative care providers about their role and responsibilities in caring for Mark and his brother, or for management of visits with the family.

MSS began the process to approve Mark's extended family as a place of safety, but did not complete a home safety check

15. Family-Centred Services Manual 3.9 & 4.2

16. Family-Centred Services Manual – 4.2 & 4.4

17. Family-Centred Services Manual – 3.6 & 3.20

18. Children's Services Manual – 4.3.2

19. Children's Services Manual – 4.3.2

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2.6 Mark's Placement with the Alternative Care Provider

MSS staff explained that high workloads prevented the completion of the Assessment and Case Plan, and that case planning was discussed during supervisory sessions

Mark remained with this alternative care provider for almost 10 months from March 18 to July 24, 2009 and from September 4, 2009 to April 1, 2010. Between July 24 and September 4, 2009, the alternative care provider was not able to care for him and requested he be moved. His alternative care provider reported that she did not receive much information about Mark from MSS when he was placed into her home. She previously babysat Mark and his brother and obtained information and support from his parents and extended family. She described Mark as a content child with no health challenges and said that he had bonded with their family very well. Visiting arrangements that included Mark's brother were organized between the alternative care provider and Mark's parents and extended family and at times occurred in the alternative care provider's home. As the MSS case worker relied on the alternative care provider to report when visits occurred, there was no listing of visits on the MSS file. Further, there was limited file information about how the children were interacting with their parents during visits.

2.7 Case Planning with Mark's Mother

In the absence of any Assessment and Case Plan, planning with Mark's mother continued to be managed through the use of Parental Services Agreements. After Mark and his brother were taken into care, a third Parental Services Agreement was signed between the MSS worker and Mark's mother for a period of three months (March 17 to June 17, 2009). The agreement stipulated that the outcome sought was Mark's mother to be mentally and emotionally healthy and provide a safe home for her children free from drugs and alcohol. Although the agreement listed the reason for involvement was parental drug use and mental health issues, there was no action identified to address the mental health issues. Rather, the agreement listed assessment and treatment for addictions, parent aide services, and regular visiting with the children as agreed-upon tasks to be completed.

Mark's mother had difficulty completing the conditions listed in the Parental Service Agreement. On one occasion the MSS worker cancelled Mark's mother's visit because she had not been visiting regularly, had not completed an addictions assessment, and was not meeting with the parent aide. Despite this lack of progress, another Section 9 Agreement and a fourth Parental Services Agreement were signed with her on June 18, 2009 because she agreed to complete the addictions assessment and have regular visits. Parent aide services were no longer included in the newer agreement, although the reasoning behind this change was not listed on the file. At the time, Mark's mother voiced being depressed and expressed some interest in the *KidsFirst* program, for which she was ineligible as she did not live in one of the neighbourhoods where it was offered. The MSS worker amended the Parental Services Agreement and included seeing her physician and meeting with a *KidsFirst* worker as additional tasks for Mark's mother to complete. The worker agreed to make the referrals for the addictions assessment and *KidsFirst* programming.

During the summer of 2009, Mark's mother completed the addictions assessment and a drug test as per the conditions of the agreement. She reported to her worker that she did not have an addictions problem; however, she voiced being depressed. Her statement about her addictions was taken at face value as no other follow-up respecting this assessment was undertaken. The child protection worker also learned that Mark's parents had ongoing conflict and Mark's father was under court order not to have contact with Mark's mother.

As indicated earlier, MSS policy[20] requires that supervisors ensure that the Assessment and Case Plan are completed, and the case plan is formally reviewed every four months. In Mark's case, this was not done. Two supervisory sessions were recorded as occurring in 2009 (in March and November) and in each session, the need for an Assessment and Case Plan was identified. New timeframes were set for the plan to be completed. Despite MSS policy and the direction provided on the file, the Assessment and Case Plan was not completed. When the file was transferred to a new child protection worker and supervisor in 2010, this requirement remained outstanding even though there were two documented supervisory reviews. MSS staff explained that high workloads prevented the completion of the

Assessment and Case Plan, and that case planning was discussed during supervisory sessions.

2.8 Mark is Moved Several Times

At the end of June 2009, Mark's alternative care provider advised MSS that she was no longer able to care for both boys. The alternative care provider explained that, including her own children, she had three toddlers and her spouse was often away working. She agreed to keep Mark; however, Mark's older brother was returned to the home of his former care provider, which meant that the boys were separated.

By the end of July 2009, the alternative care provider asked that Mark be moved as well. She stated that when the boys were placed in her care, it was meant to be a short term arrangement. She felt there was little progress being made to return Mark to his mother's care. Policy[21] requires that when there is a request for a change of placement, the MSS worker should explore the reasons for the request, and determine whether resolution is possible through mediation, additional supports or a period of respite. The MSS worker reported not recalling whether she explored other supports and documentation is not clear in this regard.

On July 24, 2009 Mark was placed into the first of two foster homes during this time. This first foster home was unable to continue to care for him and he was moved again on August 27 to another home. While Mark was in the first foster home, the foster mother reported that he displayed some disturbing behaviours that included rocking, banging his head, sticking his fingers down his throat until he gagged, and scratching the inside of his nose until it bled. This information was recorded on a placement sheet that the child protection worker prepared when seeking a new placement. MSS records also suggested that it was recorded in a blue book that goes with the child when he or she is placed in a new resource. MSS records did not reflect how the first placement was arranged, and indicated that the second foster mother picked Mark up at the MSS office. There was no documentation that indicated that the child protection worker had face-to-face contact with Mark in either foster home. MSS policy requires that a child is to be seen in the foster home within two days of placement (if the assigned caseworker did not make the placement) and the child is to be seen twice a month for the first two months.[22] It was also not clear whether any steps were taken to follow up on the previously mentioned behaviours that Mark displayed.

On August 28, 2009, Mark's alternative care provider contacted the child protection worker to advise that she wanted to care for Mark again and Mark's mother agreed with this change in placement. On September 4, 2009, Mark was returned to the home of the alternative care provider. There was no information about how placement was arranged and no indication that the child protection worker took any steps to ensure that this placement did not break down again. The alternative care provider reported that the worker did not review the situation with her or offer her family much in the way of support or respite to help manage Mark's care. MSS records indicate that she was to arrange for respite with the caregiver of Mark's brother.

2.9 The Decision to Apply to Court for Wardship of Mark

By August 2009, Mark's mother was experiencing financial difficulties. She reported being depressed, which compromised her ability to access services. She was evicted and began living with relatives in different communities. The child protection worker was aware of these difficulties but there was no adjustment made to the Parental Services Agreement.

On September 18, 2009, the Section 9 Agreement for Mark's care expired, which meant that MSS was required to apprehend him until the matter could be taken to court as per Section 17(4)(b) of *The Child and Family Services Act* or until and unless they signed another Section 9 Agreement with Mark's mother. File documentation indicated that the child protection worker believed that Mark's mother was struggling, not accepting of supports, and was not making needed changes to parent her children. On September 24, 2009, the child protection worker met with Mark's mother to try to serve her with a

There was no documentation that indicated that the child protection worker had face-to-face contact with Mark in either foster home

20. Family-Centred Services Manual – 9.2

21. Children's Services Manual – 2.8

22. Children's Services Manual – 2.6

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Notice of Apprehension for the matter to go to court. Mark's mother initially did not agree with the MSS decision to apply to the court for wardship of Mark, although she previously agreed that Mark's older brother would remain with his care provider on an indefinite basis.

In October 2009, MSS contact records indicated that the child protection worker met with Mark's mother again. The worker served her with notice of the court hearing for both boys and advised her that in order to parent Mark, she needed to find safe and stable housing, obtain random drug screens and provide the result to MSS, attend parenting or other community support programs, obtain a mental health assessment, and follow through with the recommendations and maintain regular visits with Mark.

It did not appear that MSS workers included Mark's father in any planning or discuss any programming with him to possibly care for Mark

The child protection worker also served Mark's father with notice of the court application for both Mark and his brother. In December of 2009, the court issued an order designating the caregiver for Mark's older brother as an Indefinite Person of Sufficient Interest, meaning that he would remain indefinitely in her care. The court ordered that Mark be placed in the custody of MSS as a temporary ward for three months. The court signed the order on January 13, 2010 with conditions (as previously outlined by the child protection worker) which Mark's mother would need to meet prior to Mark being returned to her care. The court order also stipulated that Mark's father could have visits, provided these were in accordance with Mark's best interests.

In the following months, Mark's mother did not follow through with these conditions, had sporadic visits with Mark, and the child protection worker lost contact with her.

2.10 Planning with Mark's Father

During this same timeframe it did not appear that MSS workers included Mark's father in any planning or discuss any programming with him to enable him to be a possible resource to care for Mark. Mark's father had unrestricted access and had visited his children. As Mark's mother was not making progress, Mark's current alternative care provider and Mark's father were considered by MSS as possible long term resources for Mark. In the fall of 2009, the alternative care provider advised the worker that she would be willing to be a long term resource for Mark if Mark's mother was not able to parent him. She confirmed her interest in February of 2010 and according to MSS records, Mark's father agreed with this plan.

2.11 Planning and MSS Contact with Mark

It is unclear as to the structure of Mark's specific planning during this time, as MSS did not complete the Child Development and Assessment Plan to facilitate and document Mark's needs, including permanency planning. MSS policy requires that a Child Development and Assessment Plan be completed within 30 days of a child being apprehended and every 120 days thereafter.[23] Mark was in care for more than 15 months without a plan. As with the Assessment Case Plan for the family, the absence of these formal plans were identified in documented supervision sessions with Mark's MSS workers, but these plans were not completed until after Mark died.

While Mark resided with his alternative care provider, MSS records reflect that the MSS worker attended the home on five occasions between April and October 2009 to see Mark. In the last four months of his placement with this alternative care provider he was only seen once at the MSS office in February 2010, which is contrary to MSS's policy, which indicates that the child is to be seen twice per month for the first two months in a placement and every six weeks thereafter.[24] Policy with respect to these child contact standards applies for children placed with an alternative care provider.[25]

The Saskatoon Crisis Nursery

The Saskatoon Crisis Nursery is a community-based organization that provides a home for children whose families encounter a crisis and request a home for their child on a short term basis. The Crisis Nursery also accepts referrals from MSS for emergency placements. Their protocol with MSS indicates that placements should not exceed three to five days, and placements beyond this time frame require approval from the Crisis Nursery Director.

On each occasion that Mark was seen when he lived with the alternative care provider, he was described as healthy, happy, and well cared for. No concerns were noted about his developmental progress, and he was beginning to walk around furniture when last seen in this home in October 2009.

Other than Mark being treated for a viral rash condition and a chest infection, the only health issue discussed with the care provider was the need for immunizations, which were still outstanding when Mark left the alternative care provider.

2.12 The Search for Another Resource

Due to unforeseen circumstances, the alternative care provider was not able to continue to care for Mark, and notified MSS on March 18, 2010 that he would need to be moved by the end of the month. She later indicated she would keep Mark until a new resource was found. The child protection worker notified each parent the following week that Mark needed a new resource. Both parents advised the worker they were going to work on having Mark returned to their care. The child protection worker consulted with an MSS manager and it was decided that Mark's mother was not able to provide for his care because she had not followed through on the case plan as stipulated by the court. No consideration was given to Mark's father as a resource; however, MSS encouraged him to locate other family members that could care for Mark. One family member came forward but then decided they were unable to provide a home for Mark.

When no resource was identified, the alternative care provider returned Mark to MSS on April 1, 2010 and he was placed by the child protection worker at the Saskatoon Crisis Nursery as there were no foster home placements available. There was no file documentation that indicated that either parent was informed about this placement. Mark's father reported that he went searching for Mark at the alternative care provider's home and no one was there. He later learned that Mark was placed into foster care.

Mark's wardship was due to expire and MSS applied to the court to obtain another three-month term to have time to develop a new case plan and resource for Mark. The court extended Mark's wardship on April 13, 2010. On April 12, 2010, another family member spoke to the child protection worker and said that her family would be a resource for Mark. This family was living in another community and advised the worker that they were previously approved by the courts as a Person of Sufficient Interest for another child. This discussion happened on the same day that Mark was moved from his emergency placement at the Saskatoon Crisis Nursery to foster care.

2.13 Mark's Placement into Foster Care

Mark remained at Saskatoon Crisis Nursery for 12 days until another resource could be located, at which time he was moved into the new foster home. During this time, the Crisis Nursery records indicated that Mark was regularly having temper tantrums and his placement exceeded the length of time that they normally would keep a child in their care. The child protection worker reported that she made a request to the Placement Unit for a resource and they were responsible to identify a foster home for him. However, it is not clear the process of how this foster home was chosen for Mark. The placement sheet that would have provided an outline of Mark's needs and the plan for the family was not found on the MSS file.

The foster home where Mark was placed was approved by MSS for no more than three children, with a noted preference of the foster parents for children under the age of five. The home had only one bedroom identified for foster children. When Mark was placed in this home, he was the fifth foster child. Three of these children, including Mark, were toddlers aged 30 months (2.5 years) or under. The other two foster children were between three and four years old. The foster family also had one school-aged child.

On April 8, 2010, the foster mother spoke to the MSS resource worker (the worker who is assigned responsibility for the foster home) about taking a fifth child in the home although it is not clear in MSS's records that this child was going to be Mark. The foster mother reported

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23. Children's Services Manual - 2.5

24. Children's Services Manual – 2.6

25. Children's Services Manual – 4.3.4

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that they had a crib in the living room for one of the children, and they had been advised that all children must have a bedroom. The foster mother agreed to explore the option of using a downstairs basement bedroom, though it was not clear who would be moving downstairs.

Crisis Nursery records indicate that their staff had discussions with the Placement Unit staff on April 6 and April 8 regarding a resource for Mark. The records indicated that the child protection worker was looking for a family resource and the Placement Unit had not been able to find a foster home for Mark. On April 8, the Placement Unit staff notified the Crisis Nursery that they had called their whole list of placements, and found someone with space. They reported that Mark would not be able to be moved until after the weekend.

The maximum number of foster children in a foster home is not to exceed four except in certain circumstances, such as keeping siblings together or keeping children in the same home for continuity

According to MSS policy, the maximum number of foster children placed in a foster home is not to exceed four except in certain circumstances, such as keeping siblings together or keeping children in the same foster home for continuity. The MSS policy[26] that allows for placement of more than four children was not followed when Mark was placed in this home, as policy recommends that when there are three children under 30 months of age, no other preschool children should be in the foster home. Further, there was no review completed to ensure that the children in the home would be safe, and that the foster family had adequate support before Mark was placed, contrary to policy.

The foster parent agreed to take Mark and picked him up at MSS's office. She was provided with child care information; however, the details of this information were not located on the MSS file. The foster parent agreed that Mark would be taken for a physical examination as soon as possible.

MSS policy[27] requires that if a worker does not place a child in a new resource, they are to see that child within two days of placement. Policy also requires that the worker have two face-to-face contacts with the child in the first two months of placement and that the majority of these occur in the caregiver's home. This did not happen for Mark. During his time in this foster home, the child protection worker did not visit Mark in his foster home at any time. The worker was not familiar with the home, and reported that she was not aware of the number of foster children residing there.

2.14 Seeking Approval for another Extended Family as a Resource for Mark

After Mark was placed with the foster family, MSS continued their efforts in seeking approval for the extended family member who came forward as a resource for Mark, upon confirming that Mark's mother was in agreement with this placement. MSS records indicate that on or before April 15, 2010, the child protection worker made a referral to the Kinship Care Unit for a place of safety and a home study (extended family assessment) for their home to be approved as a resource for Mark.

On April 19, 2010, the Kinship Care Unit made a referral to an MSS office in another region where the extended family resided for the completion of an alternative care provider home study. However after two weeks, the other region informed the Kinship Care Unit that alternative care provider approval process had not yet been started due to a lack of staff. The referral was then re-assigned back to a Kinship Care Unit staff member, who arranged to meet the family on May 19, 2010. The Kinship Care staff member recalled that the family was very anxious to have the process completed, and they agreed to send in their criminal record checks immediately. She does not recall receiving their criminal record checks and reports her documentation would have been updated the following day.

The child protection worker reported that she spoke to the family about visits with Mark to transition him to their care. She indicated that if she knew about the overcrowding in his foster home she would have tried to expedite the placement. However, at a minimum, place of safety documentation needed to be approved by a manager before Mark could be moved and she never received any documentation regarding

approval of this family as a resource for Mark. MSS staff also explained that the family resided in another region and it was felt the Kinship Care Unit would best manage the approval process.

MSS was not able to locate the file related to the information collected about this family as a resource for Mark, and informed the Advocate that this file was likely destroyed. In the days after Mark's death, the Kinship Care Unit supervisor sent an email to the Family Services supervisor to inform them of the status of this file. She indicated that MSS had received the criminal record checks and references on June 4, 2010. However, information collected for the draft Joint Death Review indicated that the criminal record checks were not received until July 5, 2010.

2.15 A Change in Planning

Once a potential resource was located for Mark, the MSS worker documented in her referral to the Kinship Care Unit that the Mark's wardship would expire on July 13, 2010, that the extended family wanted to care for Mark indefinitely, and Mark's mother was in agreement. Both parents indicated they wanted the placement to occur as quickly as possible. On several occasions, Mark's mother and her family contacted MSS inquiring about the reason the placement was delayed and were told the process took time.

At this same time, the child protection worker also informed Mark's mother that she would need to complete the court-ordered requirements and apply to have Mark returned to her care. Mark's mother reported that she was taking these steps and was considering counselling with Mark's father to address the issues in their relationship. Mark's father reported that he was taking steps with the legal system so that he could have contact with Mark's mother, and they could work together to have Mark returned to their care.

2.16 Mark's Final Months in Care

Mark spent his final months in an overcrowded foster home, sleeping in a playpen in a basement bedroom, until he was moved into a crib shortly before he died. It should be noted that his foster parents were sleeping on the main floor. On April 22, 2010, the foster parents informed the resource worker that Mark and another child, both under age two, were in the basement bedroom and the worker understood a baby monitor had been purchased.

On April 30, 2010 a cover-off worker attended the foster home to complete a home safety check, as per MSS policy[28] for all foster homes every six months. The home safety check ensures that the foster home is able to maintain the expected standards of care and the terms of their approval and their agreement with MSS. This worker noted that the home did not meet MSS's standards in that three foster children shared one room, and two foster children were in a basement bedroom, one in a crib and one in a playpen. MSS records indicate that the foster mother reported that she was given permission for these sleeping conditions but it was not made clear who gave this permission. During this investigation, the foster father reported that he felt the basement bedroom was not a suitable environment for small children.

Mark spent his final months in an overcrowded foster home, sleeping in a playpen in a basement bedroom, until he was moved into a crib shortly before he died

MSS policy[29] suggests that no more than two children should share a room (depending on size) and that all children require a bedroom. Any exceptions to this policy require Regional Director approval based on reasonable community standards. No approval was ever obtained for the exceptions that existed in this foster home. The cover-off worker also noted that there was no baby monitor purchased for the basement bedroom and MSS staff never confirmed whether one was purchased.

The cover-off worker emailed the child protection worker to advise her that Mark was sleeping in a playpen in the basement and requested that the foster parents be provided with funds to purchase a crib. A crib was provided from MSS storage, but not obtained until May 31, 2010. Mark slept in a playpen in a basement bedroom until he was moved to a crib

26. Children's Services Manual – 4.4.7

27. Children's Services Manual- 2.6

28. Children's Services Manual – 4.4.8

29. Children's Services Manual – 4.4.3

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that was vacated by the other foster child who was moved out of the home at the end of May. By June 1, another foster child (age 40 months) was placed in the home, meaning the home was again overcrowded.

The first contact that the child protection worker had with Mark's foster parents after his placement was on April 28, two weeks after he was placed, when she called to report that Mark had an ear infection for which he was prescribed antibiotics. The first "in person" contact she had with Mark after he was placed in the home was on May 14, when the foster mother brought him in for a visit with his parents.

Mark's Child Assessment and Development Plan did not get completed during his time in care. It was not completed until after his death.

The child protection worker approved supervised visits when Mark's mother could attend. Both parents visited with Mark on May 14, 2010 at the MSS office. MSS records indicate that the visit went well. Mark's mother raised some concerns about Mark's care, and the worker discussed these with the foster parent by phone the following week. Mark's father indicated in his interview with the Advocate investigator that he raised concerns with the child protection worker about the number of young children that accompanied the foster mother when visits occurred; however these were not recorded on the file.

On May 26, the child protection worker had her final contact with Mark in an office visit. He was noted to be clean, well dressed and appeared well cared for. The foster mother reported that his vaccinations were scheduled for June 2, and that she would work toward bringing these up to date. At this time, the foster mother advised the worker that Mark was sleeping in a crib. It was not clarified how he was monitored at night, given the basement sleeping arrangements that were reported in April.

On the weekend before he died, Mark had a visit with his father, his brother and extended family members. While Mark's father recalls visiting several times with Mark during this time, there is no documentation regarding these additional visits on the MSS file.

Mark's public health records indicated that when he was taken for his vaccinations on June 2, 2010, when he was 22 months old, the foster parent reported some concerns about his limited vocabulary and ability to follow simple commands. She also noted that he walked with a wide gate and did not run or kick a ball. Referrals were made for assessments by an early childhood psychologist and for speech and language pathology services, but he passed away before any appointments were made. None of these issues appear to have been discussed with the child protection worker before Mark's death on June 8, 2010. The child protection worker indicated that she had some concerns about Mark's developmental progress and that she was considering having him assessed.

Mark's Child Assessment and Development Plan did not get completed during his time in care. It was not completed until after his death. It did not identify any issues with his development and was not in chronological order, despite being approved by a supervisor. According to MSS staff, this final assessment was done for purposes of reviewing the case.

2.17 A Missed Opportunity to Review Mark's Case

In May of 2010, MSS's Quality Assurance Unit[30] conducted an internal review that consisted of a random sample of files in the Saskatoon Centre Region. Mark's file was amongst those reviewed. Details of that review indicated serious shortfalls in the documentation on Mark's file including the omission of a Child Assessment and Development Plan, noncompliance with child in care contact standards, and a lack of information about his legal status. The Quality Assurance review did not examine whether there was compliance with MSS policy[31] as it pertained to the assessment of a foster home when more than four children are placed in it, as this policy was not at the time part of the quality assurance process. The draft Joint Child Death Review observed that this policy needed to be included in future quality assurance reviews.

On May 20, 2010, the Quality Assurance Unit advised the Saskatoon Centre Region Service Director, by way of a preliminary debrief meeting and a May 28, 2010 email, that Mark's case was one that required attention. Besides a listing of

files where the legal status was unknown, including Mark's, it was not documented what specific concerns were shared about Mark's case. The Quality Assurance review sheet of Mark's file was not provided, as it was not requested. There was no evidence of any action taken by MSS staff to review the services being provided to Mark at that time. The final report of the Quality Assurance Review was provided to the Centre Region in 2011, and the region would be expected to address the issues identified to bring its services in compliance with MSS's policy.

2.18 The Aftermath of Mark's Death

As described in the previous section on circumstances of the incident (Section 1.1), Mark passed away on June 8, 2010. On the day of Mark's death, the foster mother called the Mobile Crisis Unit after he was taken by ambulance to the hospital. She reported that they were going to the hospital with all of the foster children. Mobile Crisis Unit staff contacted the hospital and learned that Mark had already arrived and had passed away. Immediate notification was provided to several MSS managers. By 6:25 p.m. that evening, Mobile Crisis Unit staff went to the hospital to follow up with the foster parents and hospital staff to determine what had happened. They learned that Mark had died of drowning and that he had extensive submersion burns to his body. This information was shared with the on-call supervisor who managed the Placement Unit. MSS managers made arrangements for all of the other foster children to be placed into another foster home and Mobile Crisis Unit staff transported them to the MSS office to facilitate the move.

File documentation shows that Mobile Crisis Unit staff contacted MSS staff, but it is not clear at what time this occurred. MSS staff learned that Mark's parents had not yet been notified and directed the Mobile Crisis Unit staff to inform them of his death. Notification was delayed as it took time to obtain contact information for the parents. At 10:30 p.m. that night, the Mobile Crisis Unit staff attended at the father's home to inform him about Mark's death. The mother was present at the home as the parents had planned to talk to the child protection worker about the reasons that Mark's placement with extended family was delayed.

The Mobile Crisis Unit report indicated that the parents wanted to see Mark's body, but were informed that he had been moved to another hospital and it was now a Coroner's case. The report indicated that Mark's parents were provided contact information to arrange for viewing of Mark's body the following day.

Mark's father and extended family reported being extremely upset about the way notification was completed. They reported that they were not "there for Mark" when he died and there was limited support in the aftermath of his death. Mark's father described the notification as "someone knocking at your door and saying your child is dead and then walking away."

On the day after Mark's death, the RCMP met with Mark's parents and extended family, and MSS workers to advise the family about the process for further investigation. There was limited information provided during this meeting. Mark's parents were informed the autopsy was going to be completed on him the following day. The draft Joint Child Death Review found that the family did not get details around how Mark died, and as a result were not prepared when they eventually viewed his remains. MSS workers reported that offers of support were made to the mother, but she declined them, indicating she had her own supports. Mark's father reported that he did not receive offers of support or any counselling until years after Mark's death.

There was also conflicting information as to when and how Sturgeon Lake First Nation Child and Family Services was notified of Mark's death. MSS policy stipulates in the case of a First Nations child, the child's band should be advised.[32] The MSS file notes indicate that there was contact with the Agency the following day. The draft Child Death Review indicated that the Agency learned of the death from the Chief of Sturgeon Lake First Nation.

Mark's family were upset about how they were notified of his death; his father said it was like "someone knocking at your door and saying your child is dead and then walking away"

30. The Quality Assurance Unit is operated by the Ministry of Social Services to assist with oversight and accountability. The Unit conducts annual reviews of MSS files to ensure compliance with provincial policy standards and makes recommendations for improvements to services.

31. Children's Services Manual – 4.4.7

32. Children's Services Manual-11.5

3.0 An Overview of the Foster Home

3.1 Approval of the Foster Home

The foster home where Mark spent his final months was approved by MSS in December 2008. To complete the approval process, a family development specialist is required to attend the home and collect certain information as outlined in policy.[33] The family development specialist attended this foster home several times and collected information required by policy to complete the approval process, including criminal record checks, medical reports, references, self-assessments, social and family history mapping and a home safety check. The foster mother herself, as well as the medical reports identified that she had certain medical conditions, but that these conditions would not affect her ability to provide care to a foster child. The family had been previously approved in Alberta to operate a licensed foster home. As part of their approval process, MSS obtained the previous home study from the other province and a copy of their license, which legally allowed them to care for up to a maximum of two children as per licensing legislation. Verbal and written references from the agency that placed children in their care were positive. The foster parents also completed training required for approval of their home. All of the information collected indicated that the family would be a good resource for children placed in their care.

The family development specialist reported that she was told that a "mutual family assessment" (home study) was not needed, as the family's application was considered a transfer from another province and information from their previous home study was transferable. The worker indicated that a file update was all that was required. However, MSS policy had no provision for an abbreviated process of approval.

The file update was completed on December 4, 2008 and file notes indicate that that the couple were living in a three bedroom home on an acreage with numerous animals, and that the father was working away from the home. The file update did not clarify how the work of caring for the acreage and the animals was going to be managed, and the family development specialist reported that the family did not identify it as a concern. The update stated that the worker had visually inspected the bedroom that the couple wished to use for the foster children, and she considered that it was large enough to facilitate two cribs or a crib and a bunk bed. She noted that the couple was willing to take up to three children under the ages of five and she recommended "that no more than three children be placed in the home." The file update was approved by the resource supervisor.

MSS policy[34] required that as part of the home study, each foster home was to be assessed based on Residential Care Services: A Building, Health and Safety Guide and the assessment were to be documented. The guidelines in place at the time stated that bedrooms should be designed for use by no more than two clients (children) unless otherwise approved by the appropriate government agency. MSS policy also required that when there are exceptions to the guidelines, the reason for the exception shall be provided and the Regional Director must provide approval. No Regional Director approval for these exceptions was found on file. A Saskatchewan foster home agreement between the foster parents and the MSS worker outlining the responsibilities of both the foster parents and MSS was signed on December 4, 2008, which completed the approval process for this family.

Prior to the completion of their training and the foster home agreement, two children who were brothers were placed in the home at the end of November 2008. The placement was done in consultation with the supervisors of the Placement and Resources Unit based on information already obtained by the worker. However, MSS policy does not have provisions for placing a child prior to completion of an approval process.

3.2 Foster Home Investigation

MSS received a number of concerns about the foster home within the first three months of its approval. The first report came in December 2008, shortly after an infant girl was placed in

the foster home. Her biological parents alleged she had bruises, cuts, severe diaper rash and was not gaining weight. Mobile Crisis and MSS staff visually checked the infant and a medical examination occurred, which confirmed the diaper rash, but no evidence of abuse was found. There was no inquiry made about the infant's weight and the infant was returned to the care of the foster parents. MSS records indicated that this infant was lactose intolerant; however, there was no documentation indicating that this information was shared with the foster parents. The supervisor who provided direction on the case consulted with a unit manager, but did not suggest that a formal investigation occur. File notes indicated these complaints were treated as "not substantiated."

A second concern was reported in January 2009, regarding the same infant's weight and diaper rash. The child protection worker did not take steps to examine the child and accepted the foster mother's assertion that the baby was gaining weight.

MSS policy[35] requires that when a complaint is made, a supervisor needs to assess the information to determine whether there is basis for an investigation. The supervisor must notify the Director or manager, as well as the MSS staff who have responsibility for the home. Where possible, a case conference is to be held to determine the response required to address the complaint. When a complaint is assessed as false or based on a standard of service or care provided, no investigation is required. If during the review, there is a concern that a child may have been abused or neglected, the matter is meant to trigger a formal investigation process. There is no documentation on the MSS file to indicate that the Director/Manager was notified or that a case conference was held, and there is no record that an investigation into the complaint occurred.

A third report came to the attention of MSS on March 2, 2009, regarding the care provided to children in this foster home. The report alleged that the foster mother neglected the infant who had been the subject of the previous complaints, and that another older child seemed to be losing weight. A case conference was held in this instance with the MSS resource and child care workers, the child protection workers and their supervisors, and the Unit managers, where the decision was made to investigate this report. This team of staff also decided that all the foster children would be taken out of the foster home for medical examinations. The file was assigned to a child protection worker to collect information and report back to the group. MSS staff explained that the investigation decision-making process at that time was a "consensual"' or "team"approach, and that the child care workers and resource worker were responsible to bring pertinent information to the team meeting for decisions to be made.

Later that same day, two staff members, the child protection worker and the resource worker, attended the foster home to notify the foster mother that there had been an allegation of neglect and that an investigation would be conducted. The foster mother had four foster children in her care (an 18 month old toddler had been placed in January) and was babysitting two other preschool children. File documentation describes concerns about the foster mother's capacity to attend to all of the children's needs. All of the foster children were moved to other foster homes and arrangements were made for medical examinations. No steps were taken regarding the two children being babysat that day as they remained in the foster mother's care. MSS sent written notification of the investigation including information about the services available from the Saskatchewan Foster Family Association to the foster parents as per MSS policy.[36]

The child protection worker collected medical reports for all the foster children and interviewed several witnesses but did not interview the foster parents as part of the investigation process. The worker did not review the child care files or the foster home file, but rather relied on the child care and resource workers to bring this information to the team. The following day, the child protection worker reported the findings to the team. They decided that the older children could be returned to the foster home as the

33. Children's Services Manual – 4.4.1 & 4.4.2

34. Children's Services Manual – 4.4.3

35. Children's Services Manual – 4.4.10

36. Children's Services Manual – 4.4.10

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medical reports found no evidence of abuse or neglect.On the same day, the interim foster parent who provided overnight care for the two older children reported concerns about their behaviour. One of the supervisors emailed the team and suggested the resource worker could address the issue with the foster parents. There was no direction given for further investigation and the two older children were returned to the home.

The following week the foster parents advised MSS that they would not take the infant back into their care. MSS decided that the toddler who had been placed with the foster parents in January was going to be returned home, which meant the foster parents were left with two foster children in their care.

The foster mother indicated she was managing with the children, but it was tougher when she needed to take them out of her home

On March 12, 2009, the resource worker met with the foster mother to follow up the investigation and review the areas of concern, including the observations made by the workers on the day the children were removed. File documentation indicated that the foster mother disputed the allegations of neglect and noted that she only babysat other children occasionally. The foster mother further explained that she was overwhelmed on the day the children were removed, with her parenting practices with older children, and her efforts to get the infant's medical needs met, which she had diligently reported to the infant's child protection worker. The foster mother reported that she was committed to three children and took a fourth child when asked. She indicated that she felt she was managing but it was tougher when she needed to take the children out of her home.

On April 15, 2009, members of the team met to review the results of the investigation. The infant's medical records indicated that the foster mother had taken the child to the doctor a number of times, and that there had been a referral to a specialist. MSS also learned that since moving, the infant's health had quickly improved and that a change in formula had been required. MSS file information did not clarify whether the foster mother was told that the infant was lactose intolerant, but noted that the doctor had not switched the formula. The team recommended that no baby with medical difficulties be placed in the home unless a specialist was already in place to provide ongoing support to the foster parent. There were no conditions placed on the home for it to remain open. The child protection worker explained that the investigation could only make recommendations, and that it was the role of the resource worker to put conditions on the home.

On the same day, the resource worker called the foster mother to advise her that the investigation was concluded, though it was not documented what level of detail was shared with the foster mother. The foster mother told the resource worker that she did not think she would want to have four children again, but was open to taking a third child.

On April 21, 2009, the resource worker sent the foster family a letter that simply stated that the allegations of neglect were unsubstantiated. There was no reference in the letter to the recommendations made by the team.

By April 29, 2009, prior to the investigation report being completed and signed off, MSS had placed another toddler, aged 23 months, in the home. The draft Joint Child Death Review report noted that this child had challenging behaviours and was developmentally delayed.

The investigation report was not completed until September 2009 and not signed off by a manager until October 2009, without any evaluation of its contents or conclusion. The report concluded the allegations could not be substantiated and that the foster mother did not purposely neglect the infant, but that she lacked the ability to properly care and advocate for the infant. The report cited the recommendation of the team that no baby with medical difficulties be placed in the home unless there was a specialist involved. The report did not reach any conclusion about the other children in the home, and did not assess contradictory evidence provided by the witnesses. Although the child protection worker

was able to explain how the evidence was assessed, this reasoning was not included in the report. The report did not make any assessment of the foster parents' ability to provide care to any child that may be placed with them.

3.3. Foster Home Overcrowding and Oversight

Between July 2009 and June 2010, the foster parents consistently had four or five children age five years and under in their care. In July 2009, the resource worker completed a six month home safety check and found no deficiencies, although it was not noted on the home safety check how a fourth child would be accommodated. The home safety check noted that three foster children shared one room and that two siblings shared a bed. MSS file notes indicated that the resource worker and the supervisor discussed the placement of a fourth child who was a sibling of other foster children in the home, and assessed the home having capacity to take more children. There was no documentation as to the reasoning provided for this assessment, and the foster mother agreed to take the fourth child. The resource worker explained that she had discussed the investigation results with the foster parents at length during this same time and encouraged them to be more vocal about the supports they needed to foster. It was her view that fostering was a partnership, and that the foster parents would be capable of knowing their limitations. The foster father explained that they understood from the investigation that the infant was lactose intolerant and there were no problems with the care provided in their home. He also thought at the time they were coping and that his wife was the type of person who would want to find room in their home for a child in need.

By August 2009, the foster home had five children placed in their care. Two of the children were infants, and the rest of the children were five years and under. The second infant had been placed in the foster home without prior knowledge of the resource worker. File documentation indicates that this overcrowded situation was discussed with the foster parent and arrangements were made for the second infant to be moved. The resource worker also informed the foster mother about the services available from the In-Home Support Program[37] operated by the Saskatchewan Foster Families Association; however, cancelled the approval process for these services when the second infant was moved.

Managerial approval was provided after the children were already placed at the home, contrary to MSS guidelines[38] which recommend that if four preschool children are in the home, no more than two may be under 24 months of age. The plan to move one of the infants was identified on the approval form; however the form did not clarify where all the children were sleeping given that the home only had one bedroom for foster children. By September 2009, the foster home was caring for four children, including a toddler who had previously been hospitalized and had ongoing medical issues.

Managerial approval was also sought after Mark's placement in April 2010 using MSS's database program. The first approval was requested on April 25, 2010 and thereafter every two weeks until Mark died. The information contained in the approval outlined the ages of all the children and the sleeping arrangements, including the fact that two toddlers were sleeping in a basement bedroom. It also indicated that the plan was for the children to remain in the home; that In-Home Support had been requested, and that none of the children had any special needs. There was no mention of the previous investigation, its recommendations or the concerns about overcrowding noted on the April 2010 home safety check. There

The MSS approval to place more than four children in the foster home did not comment on the capacity of the foster parents to manage five children

37. The In-Home Support Program is administered by the Saskatchewan Foster Families Association. Its purpose is to provide staff to assist foster parents with the daily functioning of the homes including cleaning, laundry, meal preparation and some child care or supervision.

38. Children's Services Manual – 4.4.7

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was limited information related to the assessed ability of the foster parents, and no comment about the capacity of the foster parents to manage five children.

After Mark was placed, the Placement Unit approached the foster parents about taking a sixth child. The foster parents discussed this placement with the resource worker and they agreed that they could not take any more foster children. The resource worker took steps to inform the Placement Unit about this restriction.

The foster home's Annual Review did not include any observations about the physical standards in the home

MSS policy[39] requires each foster home shall be formally reviewed at least once a year. The Annual Review for this foster home was due in December of 2009 and it was in the process of being completed at the time that Mark died. The resource worker attended the foster home on May 27, 2010 to meet with the foster parents as part of this process. Her review did not include any observations about the physical standards in the home and did not reference the concerns about overcrowding noted in the April home safety check.

The child protection worker's lack of contact with Mark while in the foster home compromised her ability to comment on the environment and the foster parent's interactions with him at home

The resource worker also obtained feedback from each child protection worker who had a child or children residing in the home. Mark's child protection worker was provided with positive feedback about the foster home. However, her lack of contact with Mark while in the foster home compromised her ability to comment on the environment and the foster parent's interactions with him at home. The draft Joint Child Death Review determined that there had only been six "in home" visits by all child protection workers involved with children in the foster home between January and June 2010, which was contrary to MSS policy,[40] as it requires that the majority of contacts occur in the foster home. The child protection worker's feedback was used to assess the ability of the foster parents to provide a safe and nurturing home environment and meet the competencies required by MSS.

3.4 In Home Support Services

MSS currently has a contract in place with the Saskatchewan Foster Families Association to provide In-Home Support programming for foster parents. This service was also available when Mark was in care. The contract includes the responsibilities of the respective parties and makes it clear that the Foster Families Association is the direct employer of the In-Home Support staff, and coordinates the delivery of services. MSS staff is required to refer the client or foster home to the Association for the provision of service and to send the Association a contract for services.

In the standard process, MSS provides the name and contact information of the foster home. The Foster Families Association recruits and interviews all potential employees and then facilitates a meeting between the foster parent and the potential employee to ensure the foster parent is comfortable with the employee. The Association encourages foster parents to refer anyone they know who might be interested to them for screening. The Association completes references checks and ensures criminal record checks and child abuse checks are obtained before the In-Home Support staff begins to provide service.

In the case of Mark's foster home, the records of MSS and the Saskatchewan Foster Families Association indicated that the standard process was not followed, since the Association did not have the name or contact information for the foster parent. This lack of information prevented services from being put into place.

MSS records indicated that on April 22, 2010, after Mark was placed in the home, the resource worker discussed getting In-Home Support with the foster mother and advised her to think of someone who might be suitable. The resource worker explained that she encourages foster parents to identify someone for their own In-Home Support, as this person will be in their home. The foster father indicated that they

understood it was up to them to locate an In-Home Support person and inform the potential employee about the needed criminal record and child abuse checks. He also reported that when their family was a licensed foster home in Alberta, they had a list of licensed respite homes to provide them with support services.

The Saskatchewan Foster Families Association's records indicated on that same day, they received a request for In-Home Support services but the referral only provided the foster parents' general location. The Association had a potential employee and provided this person's resume to the resource worker. The resource worker contacted the potential employee, explained the requirements of the Association, and said she would give the foster parent her phone number once all the requirements were fulfilled. On April 26, the Association notified the resource worker that all requirements were completed except for a child abuse check (which was available from MSS based on their records) and that the potential employee was expecting a call from the foster parent. The resource worker informed the foster mother that someone was located and she would give the foster mother her number once she had clearance.

Over the following month, there were a number of contacts between the Association, the potential employee and the resource worker. These revealed the potential employee was waiting to hear from the foster parent and was advised the resource worker would be in contact with her, as the Association did not have the foster parent's contact information. The resource worker called the Association and learned they did not have the child abuse check. The Association called the potential employee later in the month and learned she had obtained the child abuse check and was told by someone at MSS that it would be automatically sent to the Association. She informed the Association that, as she had not heard from the foster parent, she was no longer interested in the In-Home Support position.

The resource worker advised the Association that they still required an In-Home Support person, and this time provided the name of Mark's foster parent to the Foster Families Association. It received the MSS contract for In-Home Support on June 3, 2010. By June 7, 2010, the Association had another potential employee and passed this person's name and contact information along to the foster parent to arrange a meeting. This occurred on the day before Mark died.

The Association advised that if the regular process had been followed, where MSS provides the name of the foster parent, they are confident that they could have provided Mark's foster parents with In-Home Support. All previous and subsequent referrals followed the regular process, and it is not clear why this process was not followed in this case. The Saskatchewan Foster Families Association also reported that they have regular information sessions with MSS staff about how the In-Home Support program works.

MSS staff reported that foster homes were usually chosen based on the age of the child, and which foster parent had space or was willing to accept the child

3.5 Placement "Decision-Making" Process

MSS's Centre Region had a Placement Unit that managed emergency foster homes and children who are identified by MSS intake staff as requiring an emergency placement. The Placement Unit also placed children who have a caseworker (child protection worker or child care worker) and require a foster home resource. To obtain a resource, the caseworker for the child completed a placement form with information about the child. Placement Unit staff used information on the form to identify foster parents who might be suitable for a child. The form is given to foster parents when they accept a child into their home, and a copy may be contained on the child's file. It is discretionary as to whether or not this document is retained on the file every time.

At the time of Mark's placement, the caseworker for the child had no role in the decision-making related to the identification of an appropriate foster

39. Children's Services Manual - 4.4.8

40. Children's Services Manual - 2.6

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home, and was not consulted when a resource was chosen. MSS staff reported that when a foster home was identified as a potential resource, it was usually chosen based on the age of the child, and which foster parent had available space or was willing to accept the child or sibling group. Information about the region's foster homes was retained in a binder. The binder provided some detail about the capacity of the home but it was not available for this review. MSS staff indicated that binder was cumbersome to use and most often they relied upon information from the resource worker to make a decision about which home in which to place children.

One manager reported that "most times, we don't have the ability to find a suitable match [for placement of a child into a foster home], so we make a placement on who is available, who can take a kid at a particular time"

MSS's Placement Unit and resource workers were responsible for consulting with each other when a foster home was being considered to ensure that the foster home had the assessed capacity to care for a particular child. MSS records pertaining to the foster home where Mark was last placed indicated that on several occasions, it was the foster parent who reported to the resource worker after a child was already placed in their home. The draft Joint Child Death Review found that both Placement and Resource Unit staff felt that the responsibility for matching a child to a placement was the other unit's responsibility, and that children were often placed into foster homes without their resource worker's knowledge.

There was an absence of information kept that outlined why a particular foster home was approached to foster a child who needed a resource. It would appear that the foster home in this case may have been chosen because the foster parents were approved for children under five years old and because the foster parents agreed to take Mark. Further, the placement process did not appear have any mechanism or system of documentation that would track recommendations made as a result of foster home investigations. The resource worker advised that she likely would have emailed the Placement Unit outlining the recommendations of the investigation; however it is not clear if this occurred given the lack of documentation. The draft Joint Child Death Review considered placement of other children that were in Mark's foster home, and found that several of the children had special needs, including behavioural and medical challenges. These special needs were not identified when approval was sought for more than four children to be placed in this home.

In February 2015, the Centre Region changed their structure and there is no longer a Placement Unit. The functions of the Placement and Resource Units have been combined under one manager, and placements are coordinated by this newly-formed unit. MSS has advised the Advocate that further organizational changes are underway which will also affect how MSS manages the placement of children in to a foster home resource.

The new database program (Linkin) has been enhanced since it was first implemented. It now provides staff with the ability to easily identify resources for a child requiring a placement. MSS staff now have ready access to all information about a foster home, including prior investigations, and information about the child. There is capacity to document their decision-making when they are identifying a resource for a child.

Despite the changes that have occurred, MSS workers reported the difficulty in locating resources for children and commented on the resource crisis that existed at that time and continues to exist for children who require foster care. One MSS manager reported that "most times, we don't have the ability to find a suitable match [for placement of a child into a foster home], so we make a placement on who is available, who can take a kid at a particular time." It was also reported that at the present time, MSS can only match a child to a foster home less than half the time, and that obtaining a stronger assessment of the foster family when a placement is being considered would be counterintuitive because there are no other options available for placement.

3.6 The Resource Crisis

During the time that Mark was a foster child, the Centre Region (Saskatoon and area) had been experiencing an extreme shortage of foster home resources. As noted previously in this report, this resource crisis was identified by almost all MSS workers interviewed for this investigation. In February 2009, the former Advocate had released his report *A Breach of Trust: An Investigation into Foster Home Overcrowding in the Saskatoon Service Centre."*[41] He called upon government to take immediate action to deal with the resource crisis, and outlined a number of findings with corresponding recommendations in this regard. The issues included the inappropriate placement of children, chronic overcrowding of the foster home system, lack of adequate case management, inappropriate matching of children to foster homes, and placing children and foster parents in potentially dangerous situations. MSS's response, in June of 2009, described a number of planned actions to deal the situation, but there was no immediate remedy to the issues identified by the Advocate.

It is notable that within a year of this report's release and MSS's response, the Advocate was notified of the deaths of two young children in MSS's care. "Jake" passed away on December 9, 2009; and Mark died on June 8, 2010. The public report *Lost in the System: Jake's Story*[42] was released by the Advocate in 2014. It also documented significant concerns about a lack of resources and foster home overcrowding, similar to this investigation on Mark.

During the course of this investigation, MSS workers reported that foster home resources remain at a premium and there were homes that had more than four foster children placed in them. Staff expressed concern about another pending crisis, with the retirements of many seasoned and long standing foster homes in their region. The Saskatoon Centre Region reported that in February 2015, they had 161 foster homes (including regular foster care, therapeutic foster care and parent therapist homes), 19 of which were considered overcrowded, with more than four foster children placed in them.

On a provincial level, the trend of fewer foster homes is reflected in the statistics included in Appendix A. The number of foster homes in Saskatchewan has declined from 765 in March 2009, to 570 in March 2014. MSS staff also reported on a number of resources that have been developed that have been successful in maintaining the family unit and preventing the need for a child to come into care. Statistics illustrate that the number of children who are placed in an out-of-home resources by MSS has also decreased since 2009. Statistics also illustrate that placements to extended family who may be either alternative care providers or Persons of Sufficient Interest have increased significantly.

The increasing use of alternative care providers (extended family placements) is consistent with MSS policy and the *Touchstones of Hope* principles. It is apparent in review of Mark's case that MSS was intent on trying to locate and use extended family resources. However, it is also apparent that there were a number of gaps, such as the provision of support or respite for his caregiver, an absence of any training or education on the caregiver's role and responsibilities, and clarification about MSS's role to ensure appropriate oversight and case management. Given the trend that many more children in care are placed with alternative care providers, these issues will need to be monitored closely. ◆

During the course of this investigation, MSS workers reported that foster home resources remain at a premium and there were homes that had more than four foster children placed in them. Staff expressed concern about another pending crisis, with the retirements of many seasoned and long standing foster homes in their region

41. Saskatchewan Children's Advocate (former name). A Breach of Trust: An Investigation into Foster Home Overcrowding in the Saskatoon Service Centre. February 2009. Available at: http://saskadvocate.ca/media%20resources%20publications/Special%20Reports

42. Saskatchewan Advocate for Children and Youth. Lost in the System: Jake's Story. Special Investigation Report. September 16, 2014. Available at: http://saskadvocate.ca/sites/default/files//u3/Advocate_Lost_in_the_System_child_death_report_Sept_2014.pdf

Mark was a relatively healthy 22 month old toddler of First Nations ancestry. His parents faced many challenges and had difficulties in their relationship. His mother faced periods of depression and emotional instability during which she had difficulty coping with parenting. For the majority of time that Mark's parents were not able to provide for the care needs of their children, they identified family members as resources for their children. It was clearly their desire that their children not be in the foster care system.

4.0 Advocate's Findings

This investigation found that the services provided by MSS to Mark's parents were not developed in a comprehensive case plan and were inadequate to address the underlying reasons for their challenges in parenting their children. The absence of an investigation report and a risk assessment at the time that Mark and his brother were apprehended means that it is not clear whether Mark and his brother needed to remain in care.

The services MSS provided to Mark's parents were not developed in a comprehensive case plan and were inadequate to address the underlying reasons for their challenges in parenting their children

Mark was not at the centre of any case plan as there was no plan developed despite the fact he remained in care for approximately 15 months. MSS did take steps to facilitate placement with extended family members, but failed to put priority for placement with an extended family member when Mark was placed in his final foster home.

The investigation also determined that MSS failed in its duty to act as a prudent parent when it made the decision about which foster home would be suitable for Mark. The previous foster home investigation and overcrowding in the foster home were not considered when the placement decision was made. The placement decision was made on the basis of which foster home would agree to take Mark. MSS did not exercise due diligence in fully assessing the foster parents' capacity to take more than two children as per the previous home study from Alberta. Further, managerial and supervisory oversight was insufficient to address the many deficiencies found in the lack of compliance with policy in the areas of completing Assessment and Case Plans and Child Development Assessment and Case Plans, placing more than four children in a foster home, and ensuring children are seen regularly in their foster homes.

The investigation also found flaws in the manner in which MSS conducted its foster home investigation and an abdication of its responsibility to provide proper oversight and monitoring of the foster home. There were a number of opportunities missed to review the care provided to Mark, particularly in light of the heightened oversight of the Centre Region services during the time that Mark was a child in care. It is notable that these mechanisms still did not prevent his death. The findings that follow indicate that Mark's death was preventable and that there continue to be challenges in MSS's policies and practices that will need to be addressed to ensure that children's best interests are at the centre of all decision-making.

4.1 Theme One: Quality of Case Planning

Finding 1: Services provided to the family prior to Mark's birth did not address the issues that were central to the dysfunction of the family.

Despite a history of emotional instability, an unhealthy relationship and domestic disharmony, MSS did not arrange or facilitate any mental health assessment or counselling for Mark's parents or speak to the father about his relationship to Mark's mother or their children. The file related to Mark's older brother was closed prematurely, and contrary to policy as his Case Plan was completed after services ended, and without a risk assessment when he was returned to his parents' care. The basis of concluding MSS involvement was that there had been no further reports of abuse or neglect. Collateral sources were not checked. Although Mark's mother was able to complete the terms of the Parental Services

Agreement and resume care for Mark's older brother, services that could may helped both parents deal with their relationship and its impact on their ability to parent were not provided.

Article 18 of the United Nations *Convention on the Rights of the Child* specifies that "States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child and the best interests of the child will be their basic concern. State Parties shall render appropriate assistance to parents in the performance of their child rearing responsibilities."

As the history of this case demonstrates, the failure to address the parents' relationship and mental health issues meant there was a continued pattern of domestic disharmony that had an ongoing effect on Mark and his brother.

Finding 2: Case planning for Mark and his family was inadequate, and Mark's care needs were not at the centre of planning.

MSS did not use the required case planning tools to comprehensively assess the needs of Mark and his family when Mark and his brother were apprehended and during the entire time Mark remained in care.

The absence of an investigation report and use of the risk assessment tool when Mark and his brother were apprehended meant that MSS did not determine the severity of risk to the children and assess how that risk could be managed. Section 17(1) of *The Child and Family Services Act* provides the authority to apprehend a child where it is concluded that a child is in need of protection and at risk of incurring serious harm. It also directs that at any time, where an officer no longer believes that a child apprehended would be at risk of incurring serious harm if returned, the officer shall return the child to a person who has a right to custody. Although Mark's mother signed a Section 9 Agreement for residential care, which provided the authority to place the children elsewhere, an investigation report and risk assessment were needed to ensure that this agreement and plan of action was the appropriate mechanism to provide services. Furthermore, there was no assessment done of Mark's father to determine whether he could safely care for the children. In the absence of any formal custody agreement, Mark's father was entitled to be considered as a resource for his children.

The Child and Family Services Act outlines the Government of Saskatchewan's responsibility to promote the well-being of children in need of protection by offering "services that are designed to maintain, support and preserve the family in the least disruptive manner."[43] As no formal investigation was completed, which is contrary to policy, no risk assessment tool used and no assessment of Mark's father as a resource, it is not possible to establish that the children were at risk of serious harm if returned to the care of either their mother, or their father.

Case planning was reliant on Parental Service Agreements that were not responsive to the mother's needs and did not include any role for the father

The absence of an Assessment and Case Plan meant that case planning was reliant on Parental Service Agreements that were not responsive to the mother's needs and did not include any role for the father. Further, the plan did not consider the history of the parents, the scope of the problems they faced, and the underlying reasons for their difficulties in parenting their children. The Parental Service Agreements repeatedly focused on parenting skills and addictions, and failed to deal with issues of mental health and the pattern of domestic disharmony. They also referenced programs such as *KidsFirst* and Healthy Mother Healthy Baby which were not available to Mark's mother.

Mark's mother did not identify addictions as her main concern and reported a number of times that she was experiencing depression, yet the only response was to direct her to her physician. It was not until MSS decided to apply to the court for wardship of Mark that there was any mention of a mental health assessment. Her change of circumstances did not prompt any revisions to the Parental Service Agreement or address the considerable barriers she faced when she lost her residence.

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43. *The Child and Family Services Act*, Section 3

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As a method of managing case planning, the Parental Services Agreements did not ensure that Mark or his parents received the services to which they were entitled. Parental Service Agreements are intended as short term agreements and do not require supervisor approval or oversight. The Assessment and Case Plans have the capacity to capture the history of the family and identify underlying issues. They can be instrumental in helping MSS staff to apply critical thinking to their work with families, and to modify the services when progress towards family reunification is stalled. In this case, repeated reliance on Parental Service Agreements that were ineffective meant that Mark remained in care for the better part of a year without an established plan that would provide the supports that his mother or father would need to parent him.

The absence of any Child Assessment and Development Plan meant that Mark's needs were not properly assessed and were secondary in planning

The absence of any Child Assessment and Development Plan meant that Mark's needs were not properly assessed and were secondary in planning. While Mark was a relatively healthy child, reports about his disturbing behaviours when he was moved were not followed up, his immunizations were delayed and there was limited inquiry into his developmental progress.

No services were offered to preserve his placement with his alternative care provider where he resided for the majority of time he was in care, and Mark was moved several times in a short succession afterwards. No effort was made to evaluate the impact of these moves on his development or to determine what resources might be helpful to prevent any further placement breakdown when he was returned to the alternative care provider. When Mark's placement with this alternative care provider ended, it was not clear what MSS's plan was for permanency planning. The parents had indicated an interest in working with MSS for Mark to be returned to their care. Records also indicated that the new extended family might be a permanent resource.

Child care contact standards were not met during most of the time that Mark was in care, and he was not seen for over four months from October 2009 to February 2010. Child care contact standards were also not met when Mark was moved into his last foster home. The draft Joint Child Death Review found that many of the workers did not have a clear understanding of the policy regarding contact with children in care and felt that face-to-face contact in the office or away from the out-of-home placement was sufficient. In Mark's case, the child protection worker had not visited Mark in the home, was unaware that the home was overcrowded, and did not question the appropriateness of a toddler sleeping in a basement bedroom in a playpen.

With timely and appropriate case planning as per MSS policy, there would have been a focus on Mark's care needs, including permanency planning.

Finding 3: The placement decision regarding which foster home would be appropriate for Mark was made without proper assessments, did not follow policy, and was not in Mark's best interest.

When Mark was placed into the foster home, he was the fifth child placed in a home where three foster children were under the age of 30 months, and all the foster children were under age four. MSS's policy[44] allows for the placement of more than four children in a foster home when there is placement of a sibling group, placement of children who previously had been in the home, short term emergency placements, and short term respite placements. Exceptions to this policy require director or managerial approval. The policy also requires that exceptions should only be approved with careful consideration of the total placement situation. Age of the children must be a consideration and that if there are no other preschool children in the home, then three children under 30 months of age may be placed. Despite this policy, managerial approval was obtained for this placement after Mark was already in the home, and every two weeks thereafter.

MSS policy[45] also stipulates that workers review requests with their supervisors to ensure that policy conditions are met, proper assessments are made, that children will be safe, and that the foster family is receiving adequate support. Workers also are required to determine foster home capacity by considering the appropriateness of sleeping arrangements, available space, and the ability to evacuate all children in the event of an emergency.

This type of review did not occur when this foster home was identified as a resource for Mark. The placement decision was made without an adequate assessment about the impact of Mark's placement in this foster home. The child protection worker was not involved and the resource worker's involvement was limited to discussion with the foster parents about the requirement that all children have a bedroom. No one completed a proper assessment to determine whether these foster parents could safely provide care for the five preschool children in their care in this home.

When the home safety check occurred, there were no steps taken to alleviate or review the situation, despite the fact that it was learned that two toddlers were placed in a basement bedroom without confirmation that there was a baby monitor in place, when the foster parents slept on the main floor. The placement of toddlers in a basement bedroom under those circumstances and in an inappropriate environment meant that these children were in a situation of risk. Though where Mark slept was not related to his cause of death, the situation is an affront to any parent's wishes, or any community standards.

MSS policy[46] states that services to children in out-of-home care must meet or exceed the best interest of the child as defined in Section 4 of *The Child and Family Services Act*. Those best interests include the child's physical, mental, and emotional level of development, and the home environment proposed to be provided for the child. MSS has a special parental obligation to children who are in its care. MSS did not fulfill its obligations as a "parent" to Mark and other children in the home, and did not act in his best interest when his placement was arranged.

Finding 4: MSS did not act quickly to approve another extended family resource for Mark, and there were delays in obtaining the criminal record check.

MSS policies[47] [48] state that when a child's needs can be best met in a family setting, placement with extended family must be the first arrangement explored for the placement of a child, and that for a First Nations child, placement with extended family is the first priority for an out-of-home resource.

MSS did not give appropriate consideration to using a place of safety option to expedite Mark's move to another extended family resource that was willing to provide him care, contrary to policy. The extended family member had already been approved by the courts as a Person of Sufficient Interest, which meant that their home had already been scrutinized for another child. Further, they had had previous contact with Mark and wanted to care for him.

When the referral was made to the Kinship Care Unit, the child protection worker made a request for both a place of safety and home study (extended family assessment). When the Kinship Care Unit made the referral to the other region, they only identified the need for an extended family assessment, which is a longer process. Had the other region accepted the referral, the process may have moved faster given the location of the extended family. Additionally, had the child protection worker been knowledgeable about the overcrowded conditions in the foster home, there should have been recognition that another immediate resource was needed for Mark. Further,

The child protection worker had not visited Mark in the home, was unaware that it was overcrowded, and did not question the appropriateness of a toddler sleeping in a basement bedroom in a playpen

44. Children's Services Manual - 4.4.7

45. Children's Services Manual – 4.4.7

46. Children's Services Manual - 1.2

47. Children's Services Manual – 4.3

48. Children's Services Manual – 2.3

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follow up with the family by the kinship care unit on the reason the criminal records checks were not received may have facilitated an expedited process. MSS's loss of file material meant that the delay regarding the criminal record check can be only partially explained at this time.

Supervision must ensure that there is continuous evaluation of casework activity to determine if services provided are appropriate and working

The process by which this approval was handled was fraught with poor communication and a lack of understanding of the MSS policy that places priority on placements with extended family. The failure to expedite this placement meant that Mark remained in an overcrowded foster home that was not provided with any support to manage the many children placed in their care, some of whom had special needs.

Finding 5: Supervision and senior management oversight was ineffective.

MSS policy[49] requires that supervisors review each case with a worker every four months, as well as when there are significant events, such as court or changes in the family or child's case plan. Supervision must ensure that there is continuous evaluation of casework activity to determine if services provided are appropriate and working.

Mark's parents were not provided with sufficient information or support by MSS on the night of his death

There were four documented supervision sessions and several consultations with supervisors. None of the sessions indicated that there was any clinical evaluation of the casework services to determine whether they were appropriate for this family as required by policy. As there were no Assessment and Case Plans or Child Assessment and Development Plans, there was no signed supervisory approval of any case plan, contrary to MSS policy.[50] The absence of required plans was never addressed.

Senior management review pertaining to the investigation of the foster home and the approvals for the foster home to care for more than four children were delayed and appeared to rubber stamp actions that had already been taken. There was no meaningful review or critique to ensure that MSS staff and supervisors were following policy. Managers bear overall responsibility for the services provided by MSS staff, and they are in the position to address deficiencies. Their abdication of these responsibilities prevented Mark and his family from receiving the services they were entitled to receive.

Finding 6: There was a lack of leadership and appropriate direction in the aftermath of Mark's death.

MSS policy[51] requires immediate notification to the child's family and to the First Nations Child and Family Services agency when the region becomes aware of a child or youth's death. MSS management staff was advised within the hour of Mark's death, but they did not take steps to ensure that a MSS staff member or manager made contact with the family immediately thereafter. MSS staff were informed later but relied upon Mobile Crisis Unit staff to provide notification. Mobile Crisis Unit staff were involved in moving foster children to other resources and needed contact information. Notification was therefore delayed, and Mark's parents were not provided sufficient information or support by MSS on the night of Mark's death. There was also conflicting information on when or how the Agency was notified. While MSS indicates that there were ongoing efforts to offer services to the mother, these were not documented. Counselling was not offered to the father until years later.

Finding 7: Staff workload and lack of foster care resources were identified as reasons that policy was not followed.

MSS staff responsible for Mark's case all described that heavy workloads and a lack of foster care resources affected their ability to comply with MSS policy. Workloads were also attributed to delays in completion of the foster home investigation report and delays in the

foster home annual review and home safety checks. Workloads were cited as the reason the other MSS region could not complete the extended family assessment. The draft Joint Child Death Review found that the unit managing Mark's case had the highest average caseload in the Centre Service Region.

4.2 Theme Two: Foster Home Oversight and Monitoring

Finding 8: MSS's process used to approve the foster home was inadequate, and was contrary to policy.

MSS policy does not provide for an abbreviated means of approving a foster home. The use of a file update meant that the physical standards in the home were not properly assessed. The foster home should only have been approved to care for two foster children, as the foster parents only identified one bedroom for use by foster children. Any deviation from this standard required management approval, and none was sought. The absence of a detailed home study resulted in a missed opportunity to thoroughly canvas the family's current situation in terms of the time available to care for foster children, their local support systems, and the impact of living on acreage where they were raising many animals, nor to thoroughly inquire into the foster mother's medical conditions.

Finding 9: The investigative process did not comply with MSS policy, was flawed in its reasoning, and did not ensure impartiality or fairness in the dissemination of information and outcomes.

MSS policy[52] requires that an assessment be completed when there are complaints of abuse and neglect. When it is assessed that a child may have been abused or neglected, a formal investigation is required. In a formal investigation, the worker conducting the investigation shall include all persons who may have information on the child to complete a thorough, conclusive and impartial investigation. The role of the resource worker is to be a support to the foster home, and as a result these workers are not to discuss the specifics of the investigation or any interim findings, in order to avoid jeopardizing the investigation.

Following completion of the investigation, the Regional Director or designate shall convene a case conference with all workers involved to review the findings and determine the actions to be taken with respect to the children and the foster home. Under no circumstances should a child be returned prior to a review by the Regional Director or designate. According to policy, investigations are to be completed in 30 days and a written report, including the findings and an assessment of the family's ability to provide a safe and nurturing environment, is to be completed and submitted to the Regional Director or designate to determine if the investigation is complete or if further action is required. The foster family must receive a written statement of the findings and any actions being considered related to the findings of the investigation. Foster families must be afforded with the same standard of respect, fairness and due process that any other family would expect.

The foster home should only have been approved to care for two foster children, as the foster parents only identified one bedroom for their use

MSS did not assess that a formal investigation was required when the first two complaints were made about the infant's care. The lack of a formal investigation meant that there was a delay in clarifying the reasons for the infant's health challenges.

Once an investigation commenced, MSS investigating staff did not take the lead role and relied upon others to get information. File reviews and interviews with both foster parents, which were needed as part of a thorough investigation, were not completed. The foster parents were entitled to know the scope of the allegations made against them, and be given an opportunity to respond before the investigation

49. Family-Centred Services Manual – 9.2

50. Family-Centred Services Manual – 9.2

51. Family-Centred Services Manual – 3.16

52. Children's Services Manual 4.4.10

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was concluded to ensure that they were afforded a fair process. The investigating worker should have conducted this part of the process, rather than having the resource worker go over the concerns midway through the investigation. This compromised the objectivity of the investigation and the worker's role with the foster parents.

MSS's lack of adherence to policy and use of a fair process meant that there was a missed opportunity to appropriately manage this foster home

The scope of the investigation was limited to the care provided to the infant, and there was inadequate inquiry into both the care provided to the infant and to the other children in the home. No information was obtained about what the foster mother knew about the infant when she was placed in her care, how she managed the infant's daily needs, or specifics about the formula being used. The investigative report listed the information gathered and meetings held to review the investigation. The report did not assess the evidence or deal with conflicting information in any way. The conclusion that the allegations were not substantiated was based on whether the foster mother purposefully neglected the infant, rather than whether the infant was abused or neglected.

The reasoning that no infants with medical needs be placed in this foster home in the future surmised that this would be known at the time of placement, which may not always be the case. There was no recommendation to address or provide training to the foster mother to increase her skills. The process was flawed and not fair to the foster family. In the aftermath of the investigation, the foster parents were not provided with a written copy of the findings or the recommendations, and were not fully informed about the findings or conclusion.

No In-Home Support or respite was provided when the home was overcrowded, leaving the foster mother with no assistance to deal with five preschool children

MSS policy also requires that the report include an assessment of the foster family's ability to provide a safe and nurturing environment for children placed in their care. No such assessment was included in the report, and there was insufficient information collected to make that type of assessment. Had there been an appropriate assessment completed at the time, there may have been recognition that this foster family should not have been allowed to have more than three children (with Regional Director approval) in their care, given their physical space. Further, additional training should have been provided at the time to address the care concerns found prior to the placement of any more children in the foster home.

Within months of this investigation, the home was overcrowded, and children with high needs were placed there. The designated manager was not involved until the report was completed months later. Managerial review was inadequate, as it did not examine or identify the lack of compliance to policy or the inadequacies of the investigation.

MSS's lack of adherence to policy and use of a fair process meant that there was a missed opportunity to appropriately manage this foster home and ensure that the foster parents had the necessary skills and training to provide for the children placed in their care.

Finding 10: MSS did not adequately monitor the foster home, and permitted the home to be over its recommended limit without supports or appropriate assessments.

Home safety checks were delayed and initially did not properly assess the physical standards, which resulted in children sleeping in a common living area without a proper bedroom for over a year. Child care contact standards were not met, which compromised MSS's ability to ensure appropriate oversight, and to accurately assess the home's capacity to provide care. Managerial approval for placement of more than four children was sought after children were already placed in the home. Approval was provided without sufficient information to make an informed decision about whether the foster home could safely manage this number of children, and without regard to policies that suggested that the approval should not have been granted given the ages of the children placed in the home.

No In-Home Support or respite was provided

when the home was overcrowded, and the usual process to arrange In-Home Support was not followed, leaving the foster mother with no assistance to deal with five preschool children. There was never any detail obtained about how the foster mother managed the daily routine for these children on her own. No one appeared to question how a foster parent with five children under four years old was transporting children to visits or medical appointments without any assistance. The delay in conducting the annual foster home review and the lack of an assessment during the investigation or in its aftermath prevented evaluation of the foster home's capacity.

Although the resource worker discussed the investigation with the foster parents and encouraged them to be more vocal about their needs, this was not an adequate response to support them. Foster parents who open their homes to children may find it very difficult to say no when approached to take a child. While foster parents have shared responsibility in identifying their own limitations and the supports they need, MSS is ultimately responsible for the children placed in their care and must ensure that all children are safe. Article 20[53] of the *Convention* states that children temporarily or permanently deprived of their family environment are entitled to special protection and assistance provided by the State. The lack of oversight, assessment and monitoring of this foster home meant that MSS was not fulfilling its obligations to the children placed in this home.

4.3 Theme Three: Process and Systemic Issues

Finding 11: The process used by the Centre Region to identify a resource for any child lacked accountability.

MSS policy[54] requires that each region establish a primary worker for each foster home. The worker is required to monitor the standards of the home and assess the impact of placements. The resource worker, though responsible in policy for these decisions, was often made aware of placements after the fact, and thus not able to assess the capacity of the home prior to a child being placed in it. The child protection worker or child care worker who would be the most familiar with the child's needs was not involved in the process.

The Placement Unit did not have a mechanism to document their decision making as to why a particular foster home was chosen, and no tracking system to ensure that specific restrictions or recommendations from a review or investigation were followed when subsequent placement decisions were made. The process limited the capacity of the Placement Unit to match a child's needs to a resource, and as such, it was essential that there was immediate communication between the resource worker and the worker identifying the foster home.

It is too early to determine whether the recent changes to the Centre Region structure will address the concerns about accountability for placement making decisions found in this investigation. However, the improvements in MSS's database program, with the introduction of Linkin, means that MSS staff have an accessible information system to assist them in making placement decisions, and a way to document these decisions. It also gives managers access to information to help them make fully informed decisions when they are required to provide approvals.

The Centre Region was under considerable scrutiny after the Advocate's *Breach of Trust* report and would be fully aware of many of the issues found in Mark's case

Finding 12: The Centre Region did not take adequate steps to review Mark's file after deficiencies were brought to their attention.

The Centre Region was under considerable scrutiny after the Advocate's *Breach of Trust* report and would be fully aware of many of the issues that were found in Mark's case. The Quality Assurance audit a month before Mark died presented an opportunity for the region to ensure scrutiny for all cases of children in overcrowded resources. The fact that the MSS

53. United Nations Children's Fund. Implementation Handbook for the Convention on the Rights of the Child. Fully Revised Third Edition, 2007, p 277. Available at: http://www.unicef.org/publications/files/Implementation_Handbook_for_the_Convention_on_the_Rights_of_the_Child.pdf

54. Children's Services Manual 4.4.7

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manager took no action to immediately review the case speaks to a lack of accountability for the review process. Article 25 of the United Nations *Convention on the Rights of the Child*[55] recognizes the right of a child who has been placed by competent authorities for the purposes of care, protection or treatment of his or her physical and mental health to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement. It provides a safeguard to a child from abuse by the State. When deficiencies are found, it is incumbent on the state who is acting as parent, to take immediate action to address the deficiencies.

Article 25 of the *Convention* recognizes the right of a child in care to a periodic review of the treatment provided and all other circumstances relevant to his or her placement

The opportunity to thoroughly examine Mark's case and take steps to address any deficiencies found in the foster home was missed, as was the ability to address the stalled process for placing Mark with an extended family member.

Finding 13: A lack of resources continues to present a challenge to matching children who require a foster care placement to suitable resources.

A lack of resources means that overcrowding continues to be an issue for MSS staff looking to find an appropriate resource for a child who requires a placement. It was the underlying reason that Mark was placed inappropriately in an overcrowded foster home. MSS statistics up to March 2014 show that there has been a reduction in the number of children placed in overcrowded foster homes, and there is also a reduction in the number of foster home resources available for children. The Advocate notes that in the latter part of 2014 there has been an increase in overcrowded homes which is being monitored. MSS staff report the potential for another pending resource crisis and the lack of current capacity to match a child to a foster home resource. MSS policy requires that staff match children to a resource, and a lack of resources compromises the ability of staff to follow this policy.

Finding 14: MSS has significantly increased its reliance on the use of the Alternative Care program. A recent MSS review of the Alternative Care has made recommendations towards improvements in that program.

MSS's statistics demonstrate that there has been a steady increase in the use of alternative care providers as resources for children. This practice is supported in legislation, policy and children's rights principles. MSS did take appropriate steps in its attempts to use this program when seeking a resource for Mark, and was diligent in obtaining parental approval when these placement decisions were made.

Mark spent the majority of his time in care with an alternative care provider. At the time, policy stipulated that he was entitled to the same level of services and resources of any child in care. However, it would appear that his alternative care provider did not have the same level of support or respite available as foster parents did, and there was a lack of clarity in terms of her understanding of her role and responsibilities. There have been improvements to policy since this time, as there is now a requirement that an agreement be signed with alternative care providers, which can assist in ensuring that they are knowledgeable about the roles and responsibilities that both MSS and they have for the care of the child. The agreement specifies that MSS will provide support and consultation services to the caregiver(s), consistent with the needs of the child. Services such as respite, access to training and other forms of support are not clearly spelled out in policy.

The MSS review has recommended improvements to the program that include training and increased awareness of support services currently in policy. MSS has already initiated action to implement these recommendations and is developing an outcome based measure to evaluate the Alternative Care program. The Advocate is pleased to hear of this initiative and will follow up with MSS on its progress. ◆

55. United Nations Children's Fund. Implementation Handbook for the Convention on the Rights of the Child. Fully Revised Third Edition, 2007, p 379. Available at: http://www.unicef.org/publications/files/Implementation_Handbook_for_the_Convention_on_the_Rights_of_the_Child.pdf

5.0 Advocate's Recommendations

It has been five years since Mark's death, and the Advocate recognizes that MSS has made significant changes toward improving the services provided to children and families. Improvements such as implementing the Structured Decision Making® risk assessment tools have arguably made a better system for evaluating risk and improved planning in working with families due to the elements of structured rigorous assessment and increased case management procedures. The new electronic database for documenting and sharing information, enhancing case documentation and increasing supervision, along with its ability to track foster homes for available spaces, is noted. MSS policy with respect to building, health and safety requirements has also undergone significant changes. Safe sleeping standards are included in policy and do not permit the use of playpens as beds, except for very limited periods of time, and specify that children under age eight sleep in an area where a capable adult has ready access in case of an emergency.

It has been five years since Mark's death, and the Advocate recognizes that MSS has made significant changes toward improving the services provided to children and families

In spite of these changes, my office observes the continuation of chronic and persistent systemic issues pertaining to the lack of quality case management and supervision, lack of policy compliance generally, adherence to required contact standards when a child is placed into an out-of-home resource, the lack of thoroughness and integrity of investigations, and the continued need to place children in foster homes which are overcrowded or over their recommended capacity. Several themed findings highlighted in this investigation were also found in two of our other reports entitled *Two Tragedies: Holding Systems Accountable* and *Lost in the System: Jake's Story* that we released in 2014. Recommendations made in those reports are relevant to the findings of this investigation, and as such, are restated below. The rationale for restating these recommendations is to highlight the importance of addressing them to improve quality outcomes. In addition, the findings from Mark's case have generated some new recommendations that are required to address deficiencies in practice.

5.1 Relevant Recommendations from *Two Tragedies: Holding Systems Accountable*

#14-24031

That the Ministry of Social Services ensure high quality child protection casework by implementing:

- **a method for evaluating the quality of case practice and decision-making (focusing on integrity/fidelity in the use of SDM® tools);**
- **a formal competency based certification program to develop staff competence in the use of SDM® tools; and**
- **a method for clinical oversight for effective supervision and monitoring of casework to ensure identified needs are incorporated into the case plan and policy standards and compliance are met.**

Mark's mother was a young person who was transitioning from receiving services from MSS to becoming a parent. The Advocate remains troubled by MSS's commitment to young people who transition to adulthood without adequate support and services. Mark's mother faced considerable challenges in her new role as a parent, and MSS did not adequately assess or provide the services she needed. There also did not appear to be effective clinical oversight when the services that were provided did not seem to be helping her achieve the plan to reunite her with her children. Further, MSS consistently did not consider the role of Mark's father in his life, despite the fact that he remained a key figure in the lives of his children.

The Advocate understands that MSS has accepted this recommendation from the *Two Tragedies* report, and we will continue to monitor the process of its implementation.

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#14-24032

That the Ministry of Social Services contract with the Children's Research Centre to complete an SDM® workload estimation study that establishes caseload policy standards for Saskatchewan. Once the study is completed, implement the recommended standards.

Workloads were identified as the reason MSS staff were not able to complete the case planning as required by policy in managing Mark's case. Delays in completing the report of the foster home investigation, in conducting required home safety checks and the annual review of the foster home were also attributed to workloads. Further workload and staffing issues were cited as the reasons another MSS region could not assist with completing the home study of the extended family that was willing to be a resource for Mark.

MSS has accepted this recommendation and has reported that they are currently in the initial stages of developing the scope of the study and sites in which to pilot test it. The Advocate is concerned that nearly a year has passed and the study parameters are still in the developmental stages. Workloads continue to be cited as a theme to rationalize noncompliance with policy. It is imperative that MSS prioritize this study to fully understand what is required to ensure that practice is followed. The Advocate will continue to monitor the full implementation of this recommendation.

5.2 Relevant Recommendations from *Lost in the System: Jake's Story*

In our other recently released public report *Lost in the System: Jake's Story*, recommendations were made that are relevant to the current concerns the Advocate has regarding the number of moves a child experiences, foster home care and licensing of foster homes.

#14-24048

That the Ministry of Social Services complete a study that includes a review and analysis of the number of moves children and youth experience in out-of-home care and provide a report to the Advocate. This study should include:

- **a random sample of children in emergency receiving homes, group homes and alternative care from the past two years;**
- **the number of moves and rationale for each move a child in the sample experienced; and**
- **the method of approval for the moves.**

#14-24049

That the Ministry of Social Services fully implement the software for the Linkin Information Database to allow for data collection to monitor the number of placements of children and youth in out of home care provincially.

Data collection is essential to assist MSS in monitoring the number of placements of children in care and in minimizing the number of moves a child experiences. As was the case with Jake, as described in *Lost in the System: Jake's Story*, Mark experienced a number of moves as a result of placement breakdowns with his alternative care provider. Information about the number of moves and rationale for them could provide MSS with information about what types of supports or services might be appropriate to limit moves. Acquiring and acting on this knowledge will assist out-of-home care providers and prevent additional moves for children, thus minimizing the additional trauma children experience every time they are moved.

MSS has indicated that it has completed a report that addresses both of the above recommendations which the Advocate is currently reviewing. These are cited as relevant to Mark's case and, pending our assessment of the report, there may be more information and follow-up required to satisfy this recommendation.

#14-24050

That the Government of Saskatchewan amend *The Child and Family Services Act* (or any legislation replacing this act) or its regulations for the licensing of foster homes.

Over the course of six years, the Advocate has called for licensing foster homes in the *Breach of Trust* report, and *Lost in the System: Jake's Story*. The case of Mark again illustrates the need for licensing as a mechanism to ensure accountability for MSS and for protection of foster parents. Licensing will improve public confidence that the government is accountable and it will raise the bar to the highest level in ensuring that the rights, interests, and well-being of children and youth are respected.

As indicated in my previous reports, Alberta, Manitoba and Ontario all license foster homes and these licenses must be renewed on an annual basis. In the case of Mark, the foster mother had been licensed in Alberta to foster only two children. Their tiered system provides a mechanism in law that ensures capacity is not exceeded unless the foster parents are approved legally for more children. This high level threshold rooted in law is critical in protecting children and the parents who care for them. In this investigation, the Advocate learned that MSS used the other province's home study, which assessed their capacity for only two children, to approve them to foster in Saskatchewan, yet placed five children under the age of five in their care, and at one point asked them about taking a sixth child. The rationale for licensing is the accountability of following law, not simply policy that can change at any given time. Saskatchewan has a good model to follow with its *Child Care Act* and *Child Care Regulations* for licensing child care centres and homes. Entrenching provisions in law will provide the safety net required to ensure the highest standard of care and protection for children in out-of-home care, who are some of our most vulnerable citizens.

MSS has indicated previously that it has not accepted this recommendation to license foster homes, as they are confident that MSS policies are sufficient to provide accountability and oversight of the foster care system.

#14-24053

That the Ministry of Social Services amend policy to conduct mandatory investigations of foster home incidents involving highly vulnerable children, including documentation and gathering information from collateral sources such as staff and other children in the home.

In Mark's case, early complaints about care provided to an infant in the care of the foster parents were not formally investigated. Amendments to policy would ensure sound decision making and provide clear direction to staff about the need for investigations for highly vulnerable children, such as those under age three, non-verbal children, developmentally delayed children, or those with high medical or behavioural needs, all of whom require the highest level of protection.

#14-24054

That the Ministry of Social Services require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies.

As illustrated in Mark's case, there were many times when this foster home was over its recommended number of children for placement. Managerial approval and oversight was not adequate to ensure that policies regarding placing more than four children in a home were followed. The Advocate is also concerned about situations in homes with the maximum number of foster children residing in them that also have other children residing there, as the maximum number of children only considers foster children, not biological or adopted children who may also be living in the home. Situations have come to our attention in which foster parents are overcrowded with foster children, and are caring for other children as well, which has not been considered when placing foster children in the home. We are currently exploring this issue with MSS.

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5.3 Advocate's Recommendations in Mark's Case

As noted above, the Advocate is making the following recommendations specific to this investigation, in addition to those made in our other reports. Although Mark's death occurred five years ago, issues of noncompliance with policy and practice standards continue to be as deeply troubling today as they were five years ago. The Advocate recognizes MSS's attempts to address some critical issues to work toward improving quality outcomes for children in care. Unfortunately, the themed findings we identify in this death five years ago are the same as those we see today in our investigations, which tells the story of a systemic problem. This can only be solved with a systemic solution that is rooted foundationally in a competency-based mentoring process for practice improvements that focus on improving quality outcomes. The above recommendations speak to this, in addition to these new recommendations that are warranted to improve policy and practices and address gaps in MSS's provision of services.

Recommendation 1: **That the Ministry of Social Services conduct a review and amend its policies pertaining to the investigation of foster homes to ensure that investigations are conducted in a thorough and comprehensive manner, and are compliant with the principles of fairness. The following elements of the existing policy need to be amended to ensure:**

- independence in assignment of the investigation to ensure that the investigating officer has no relationship with the foster home or any staff associated with the home;
- the inclusion of practice guidelines in the assessment and documentation of evidence;
- the inclusion of a Structured Decision Making® risk assessment tools or similar tools to assist staff in making decisions about if or when children must be removed from a foster home when an investigation is undertaken; and

- an outline of the assessment required to determine the family's ability to provide a safe and nurturing environment for children placed in their care.

Recommendation 2: That the Ministry of Social Services provide training to staff who are assigned to conduct or supervise foster home investigations related to the principles of fairness and their application to an investigation process.

There were numerous shortcomings in the investigation into the complaints about the foster home where existing policy did not appear to provide sufficient direction to staff and managers about what was needed to conduct a comprehensive investigation. Use of a consensus approach compromised the independence and thoroughness of the investigation. It is critical that an independent and objective framework and approach is used to ensure due diligence. Although there have been changes to the policy that clarify the requirements to conduct a thorough investigation, further amendments and staff training are needed to ensure that children in care are protected, and that foster parents are treated fairly when an investigation commences.

Recommendation 3: That the Ministry of Social Services conduct a review of their foster home program, in order to determine those factors that have resulted in a rapid decline in the number of foster homes, and that includes a plan to address this decline.

As indicated above, the Advocate has previously made a similar recommendation in *Lost in the System: Jake's Story* which calls for a provincial review of foster homes. The purpose of this recommendation is to understand the landscape of operational compliance for these homes. The spirit of this recommendation is to understand and strategize how to address the issues which have led to a decrease in the number of foster homes, in order to engage in proper planning to avoid a potential resource crisis.

Recommendation 4: That the Ministry of Social Services amend its policy to require that an In-Home Support contract and required staff are in place prior to the placement of a child, when it is assessed that a foster home requires In-Home Support services.

In-Home Support services were never in place for the foster home where Mark was placed, despite the fact that this home was repeatedly over its assessed capacity. The foster parents were not provided with adequate information about how the program operated, and there was a lack of communication about who was managing the process, which together resulted in a missed opportunity to put needed services in place when Mark was in the foster home. In-Home Support services would have provided the foster home with increased ability to provide a safe and nurturing environment for the children in their care.

Recommendation 5: That the Ministry of Social Services evaluate the recent changes made to the structure of its placement process and provide a report to the Advocate for Children and Youth in six months that outlines the impact of those changes on the ability of staff to match a child to an out-of-home resource.

Recommendation 6: That the Ministry of Social Services include the use of the Structured Decision Making® placement matching tool, or similar tool to guide placement matching decisions.

The placement process in Mark's case was not able to ensure that the policy provisions in matching a child to a resource could be met. It is imperative that the new process is reviewed and changes made, so that the best resource can be arranged for a child who requires a foster home placement. Use of an SDM® or similar type of tool would support best practices and ensure that all staff are using the same considerations when making a decision about the rationale for placement of a child into a particular foster home.

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Recommendation 7: That the Ministry of Social Services develop internal procedures to ensure that issues requiring immediate attention, as identified through a Quality Assurance Unit review, are addressed in a timely effective manner and the actions are reported back centrally.

The opportunity to review Mark's case was missed when MSS staff did not immediately respond to the findings of the Quality Assurance review. The immediate review of Mark's case may have shed light on the failed home safety check and the reason for delays in the approval of extended family as a resource for Mark. Requiring that actions are reported back to MSS's central Quality Assurance Unit will improve accountability when deficiencies are found.

Our office has long advocated for the transformation of the child welfare system towards reconciliation and reparation

Recommendation 8: That the Ministry of Social Services create and implement procedures in their current policies related to a critical incident or child death that includes:

- **immediate notification to the natural family by a Ministry of Social Services supervisor or manager that includes all pertinent information available;**
- **immediate offers of support services and regular follow up with family members to address issues of grieving and loss; and**
- **immediate notification to the First Nations bands or agency by a Ministry of Social Services manager that includes all pertinent information available.**

The manner in which MSS managed notification to Mark's parents when he died failed to deal with their profound loss and the severity of the situation. Immediate notification to the First Nations agency by a senior manager is also required. This issue was raised in the *Breach of Trust* report prior to Mark's death. In their response, MSS's view that the policy was sufficient failed to anticipate the need for very specific guidelines during a time of crisis.

Recommendation 9: That the Ministry of Social Services offer an immediate formal letter of apology to Mark's parents for not acting in Mark's best interests during the time of his last foster home placement. The apology must acknowledge that:

- **the Ministry of Social Services did not make a proper assessment at the time Mark was placed into this foster home;**
- **the Ministry of Social Services did not act quickly in its approval process for another resource for Mark;**
- **the Ministry of Social Services failed to take opportunities to review Mark's case when notified there were deficiencies; and**
- **the Ministry of Social Services did not take appropriate steps to immediately notify Mark's parents of his death, prepare them for how he died, or continue to reach out to them after he died.**

The letter of apology should also include an offer to each parent of any resources that they may still need in dealing with their grief in the loss of their child.

Our office has long advocated for the transformation of the child welfare system towards reconciliation and reparation. The Touchstones of Hope were formally adopted by the Advocate for Children and Youth to speak to the principles of reconciliation in child welfare that holds relationship-building, acknowledging, truth telling and restoring as paramount principles for improving outcomes for children, youth and their families. The Ministry of Social Services has also adopted the Touchstones principles at the encouragement of our office.

The first step towards redress and reconciliation in its very simplest form is that of an apology. Although many years have passed since Mark's death in foster care, an apology provides his parents with an acknowledgement of MSS's failures to act in Mark's best interests. Apologies are the foundation of relationship-building or, as the case may be, re-building, and are an act in the spirit of reconciliation. An apology would pave the way forward for rebuilding relationships and healing the painful loss of Mark for his family and community, whereby MSS acknowledges their accountability for their actions. ◆

Mark's story demonstrates how tragic events can occur when there are repeated failures to follow policy, and when oversight mechanisms fail to address matters of persistent noncompliance. I have called this report *No Time for Mark: The Gap Between Policy and Practice* because the repeated evidence of noncompliance cited in this investigation illustrate that MSS staff did not take the time to follow policy and provide Mark and his family with properly planned case management services.

6.0 Concluding Remarks

MSS was responsible to ensure that policies were followed and deficiencies addressed when brought to their attention. Time appeared to be a factor when an expedited process was used to approve the foster home outside of the scope of policy, and when required assessments of the foster home were not completed. While using a group approach to investigations may have been seen to be timely, it compromised fairness in its process and decision-making. The placement decision that was made for Mark's final placement in a foster home was made outside of policy and under the pressure of time and a resource crisis. MSS staff and managers did not appear to take the time to apply critical thinking to their decision-making when approving the foster home investigation report and in approving the foster home for more than the recommended number of children. Time was a factor in arranging for Mark's placement with an extended family member who could have been a resource for him. Most importantly, Mark had the right to the time needed to be seen and assessed in the place he was living. Sadly, MSS staff did not personally notify Mark's parents in a timely and compassionate manner when he died.

While Mark's death was ruled accidental, I have also concluded that it was preventable. MSS failed to act in Mark's best interests when it placed him in a foster home which was not properly assessed and was not supported to provide care to the numbers and ages of children in the foster parents' care. His placement was made in spite of, and contrary to, MSS policy. MSS placed Mark in a situation of extreme risk, and that risk was not managed, when approvals were given to place more than four children in the home. To seek a small measure of redress for Mark's family, I have recommended that MSS send an apology by letter to Mark's parents that acknowledges MSS's role in his death.

The fact that Mark's death occurred five years ago and that MSS has made many changes and improvements to its services is of little solace to his family and does not lessen the impact of his story. As indicated earlier, I recognize the work MSS has done to improve its policies and to significantly reduce the number of children in foster homes with more than four children. The decreased number of children in care is also a testament to MSS's efforts and those of other child-serving agencies to provide preventative services. That said, I remain deeply concerned that during this investigation, MSS staff reported on the potential for another resource crisis and on the continued inability to follow placement policies due to limited foster care resources.

The recommendations I have made are intended to address issues of noncompliance, lack of oversight and make improvements in MSS's practice. I have also made a recommendation to deal with the declining number of foster home resources. These matters must be addressed, as these resources are an integral part of MSS's services to children, youth and their families. Although MSS has not accepted the need for licensing of foster homes, I will continue to advocate for consideration of this recommendation.

Mark and his family were entitled to the time needed to ensure that they were provided the highest quality of child welfare services. As we have learned from Mark's story, all child-serving ministries and agencies must prioritize their time to act in the best interests of our children and youth.

I wish to thank all those who contributed to this investigation. While it is too late to make a difference for Mark, it is our hope that by implementing the recommendations in this report, we can close the gap between policy and practice for the children who come after him.

This report is dedicated to Mark and his family.

Bob Pringle

Bob Pringle

Appendix A: Statistics on the Child and Family Services

Number of Children In Out-of-Home Care	Mar 31, 2010	Mar 31, 2011	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
Children in out-of-home care[1]	4776	4755	4591	4504	4518

All data is taken from either the monthly Linkin extract or ACI and includes active cases at month end.

1 This number includes all children who are placed in out-of-home care and are involved with the Ministry and children who were apprehended by the Ministry off-reserve and placed on-reserve.

Children In Foster Homes	Mar 31, 2009	Mar 31, 2010	Mar 31, 2011	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
The number of foster homes[1] the Ministry has in the province	765	709	679	634	619	570
The number of foster children[2] in foster homes	1985	1676	1486	1364	1257	1153
The number of foster homes[3] with more than four foster children	133	88	78	68	58	50
The number of foster children in foster homes with more than four foster children	874	557	467	403	339	297

Data Source: All data is taken from either the monthly Linkin extract or ACI and includes active cases at month end.

1 These are approved providers who service types include Regular Foster Care, Therapeutic Foster Care, Parent Therapist, or both Regular and Therapeutic Foster Care.

2 Children refers to children in care.

3 As of March 31st each year using approved providers and counting placement types of Foster Care; Therapeutic Foster Care; and Parent Therapist.

System in Saskatchewan from 2009 to 2014

Children with Alternative Care Providers	Mar 31, 2009	Mar 31, 2010	Mar 31, 2011	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
The number of alternative caregivers approved by the Ministry[2]	213	426	422	–	574	596
The number of children the Ministry has placed with an alternative caregiver[3]	73	367	423	–	423	461

Data Source: All data is taken from either the monthly Linkin extract or ACI and includes active cases at month end.

Children with Person of Sufficient Interest Placements	Mar 31, 2009	Mar 31, 2010	Mar 31, 2011	Mar 31, 2012	Mar 31, 2013	Mar 31, 2014
The number of children that the Ministry has placed as an indefinite PSI[4]	1297	1428	1538	1627	1660	1674
The number of PSI homes/families[5]	306	302	507	–	956	890

Data Source: All data is taken from either the monthly Linkin extract or ACI and includes active cases at month end.

1 As of March 31, 2012, some Ministry offices were already converted to Linkin while others were still using ACI. Compiling statistics from these two different systems is not recommended as there are differences in the way alternate care providers and the children placed with them are captured. For instance with ACI, if a provider was an approved foster care provider they could only be recognized as a foster care provider and not also having been approved as an alternate care provider.

2 For March 31, 2009 to 2011 the data source was exclusively ACI and the AC subprogram was used to identify alternative caregivers. For March 31, 2013 and 2014 the data source was Linkin and the following criterion was used: Approved Providers with an active Alternate Care Service Type.

3 For March 31, 2009 to 2011, children placed with an alternate caregiver were identified using children in care of the Ministry (wards) who also had a CA (Alternate Care) role. The selection criteria for March 31, 2013 and 2014 involved isolating children with an "Alternate Care" Placement Type who were placed with approved providers with an active "Alternate Care" Service Type.

4 This number includes children/youth who are placed by court order in the custody of a designated Person of Sufficient Interest caregiver. ACI did not distinguish between definite and indefinite PSI children and to provide reporting continuity for March 31, 2013 and 2014 the statistics include both definite and indefinite PSI children.

5 For March 31, 2009 to 2011 the data source is exclusively ACI and the PI subprogram was used to identify person of sufficient interest caregivers. For March 31, 2013 and 2014 the data source was Linkin and the following criteria was used: approved providers with an active Person of Sufficient Interest Service Type.

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